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Teams in Action: Primary Health Care Teams for Canadians

Health Council of Canada | Conseil canadien de la santé

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Production of this report has been made possible through a financial contribution from Health Canada. The views expressed herein represent the views of the Health Council of Canada acting within its sole authority and not under the control or supervision of Health Canada. This publication does not necessarily represent the views of Health Canada or any provincial or territorial government.

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Development of this report was led by the Council's Monitoring Committee, which includes Councillors Dr. Alex Gillis and Ms. Lyn McLeod (co-chairs), Dr. Jeanne Besner, Mr. Jean-Guy Finn, and Dr. Les Vertesi. The Council also thanks Dr. Diane Watson (Associate Faculty, Centre for Health Services and Policy Research, University of British Columbia) for her contributions to the initial research and development of the report.

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FOREWORD

In 2004, governments committed to increase the use of primary health care teams in Canada, with a goal of 50% of Canadians having access to these teams by 2011.* Governments were concerned about the aging population and the increasing number of Canadians with chronic conditions, and using teams of health care professionals was seen as one promising way to help strengthen primary health care in Canada.

Teams allow doctors to focus on medical diagnosis and management, while other health professionals (such as nurses, dietitians, and social workers) provide other services and work with patients to help them improve their health habits and the way they manage their conditions.

Five years later, what do teams look like across the country? And what do primary health care teams mean to you, as both a patient and a taxpayer?

This report answers these questions and more. We looked at research that had been done on team-based care, and interviewed the federal, provincial, and territorial governments to find out about their progress in developing teams. We learned that team-based care in Canada is a creative mosaic of various types of teams, serving a wide range of Canadians with different health needs. Many jurisdictions use teams in rural and remote regions where there aren't enough family doctors; to manage chronic diseases such as diabetes and heart disease, often with innovative approaches tailored to their communities; to provide overall primary health care to specific communities; and to reach out to vulnerable or high-risk populations. In some cases, community-based teams have been structured to play a role beyond medical care and health promotion; they also serve as catalysts for change, working to improve the broader community health and lifestyle factors that put their patients at risk.

What we don't know—yet—is the impact of all this promising activity. Research strongly supports the use of collaborative team-based care for people with chronic diseases, for mental health issues such as depression, and for some specific populations—but there isn't enough evidence to date that shows whether teams make a difference to the general population. We also need to know whether Canadian teams have the right mix of professionals for the patients they serve, how much and how well professionals truly collaborate with one another, and how this ultimately benefits their patients. Better evaluation of all these factors is needed. That's how governments will know how to use teams most effectively in the future, not only to improve the health of Canadians, but to ensure that we spend our health care dollars wisely.

JEANNE BESNER, RN, PHD
CHAIR, HEALTH COUNCIL OF CANADA

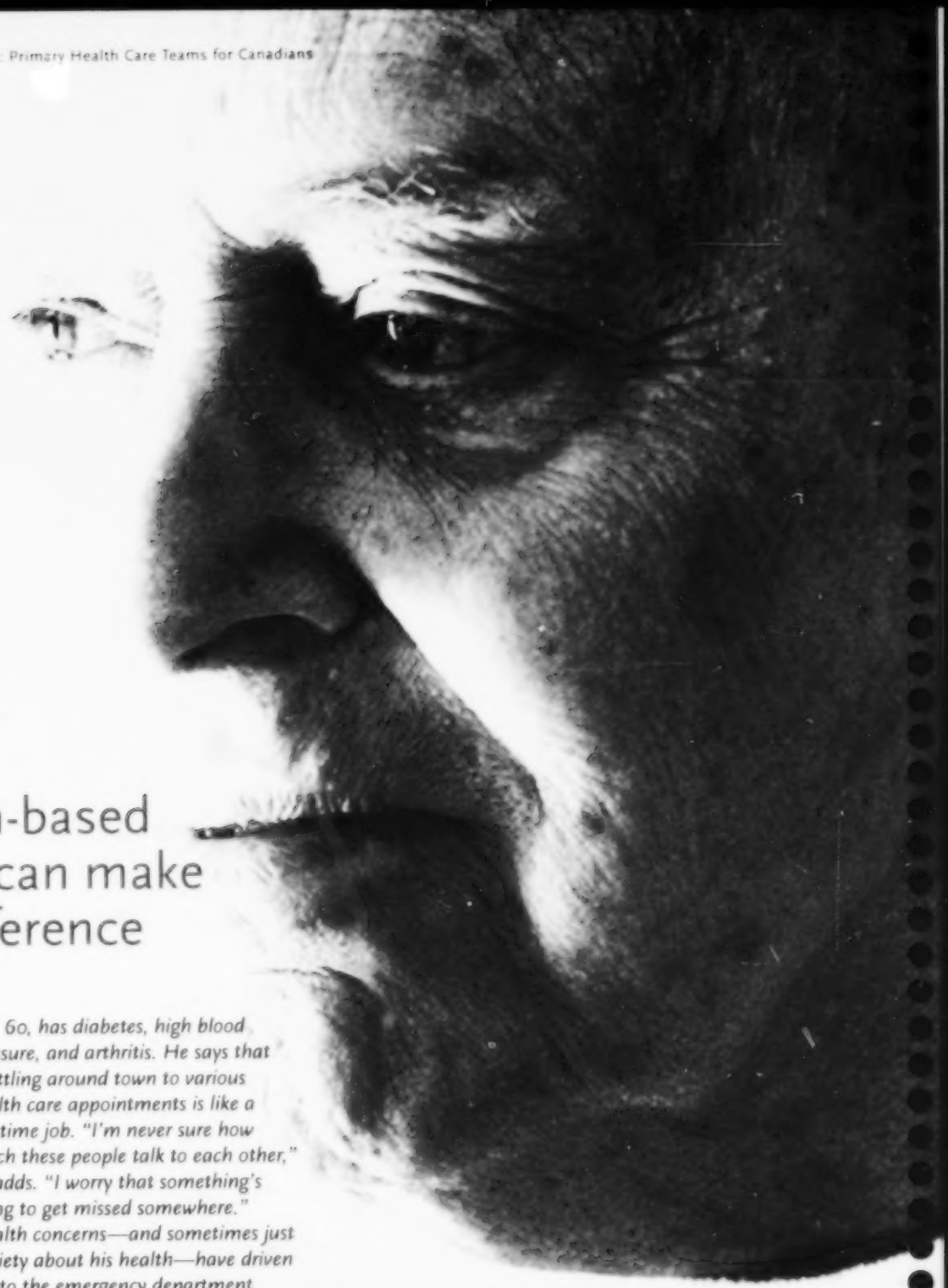
5 YEARS LATER

What do teams look like across the country?

What do primary health care teams mean to you, as both a patient and a taxpayer?

*For more information, see ***What governments promised*** and ***A history of teams in Canada*** on page 50.

Be sure to read the stories in this report that show the difference teams are making in the lives of Canadians. *Teams in action* stories begin on page 24.



Team-based care can make a difference

Joe, 60, has diabetes, high blood pressure, and arthritis. He says that shuttling around town to various health care appointments is like a full-time job. "I'm never sure how much these people talk to each other," he adds. "I worry that something's going to get missed somewhere." Health concerns—and sometimes just anxiety about his health—have driven Joe to the emergency department more than a few times. His wife adds that Joe doesn't always follow what he has been told by the different health care professionals about taking care of himself. "I think he's overwhelmed and depressed," she says.

Joe would likely benefit from access to a primary health care team, commonly described as two or more health care professionals working together in a coordinated, integrated effort to provide a patient's basic health care.[1]

Research shows that team-based care can offer better access to services, shorter wait times, better coordination of care, and more comprehensive care than a single health care professional alone.[1]

In addition, doctors who are part of a team can focus their time on medical issues, allowing other health care professionals (such as nurses, dietitians, and social workers) to provide patient education on healthy living or how to manage chronic conditions more effectively.[2]

Given this support, it's not surprising that people who receive care from teams report that they are more knowledgeable about their health conditions.[3] Research also shows that people in team-based care tend to make fewer visits to doctors and hospitals.[4]

There's a growing body of evidence that illustrates how team-based care improves people's health. The research is particularly strong in support of using teams to care for people with chronic health conditions such as diabetes or heart disease, for mental health issues such as depression, and for other specific populations, such as the elderly. These people can see improvements in both their health and overall quality of life.[1,4,5,6,7,8]

Teams are also an effective way to provide primary health care services to rural, remote, and under-serviced areas that don't have enough (or any) family doctors.[9,10]

Research supports the use of teams to care for people with chronic conditions and other specific populations, and to provide primary health care in areas that don't have enough family doctors.

Some positive effects of team-based care

- A review of studies about the use of collaborative care for people with depression showed that, compared to usual primary care, people experienced improvements that were still seen up to five years later.[7]

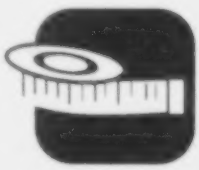
- Diabetes patients receiving team-based care reported better health results such as lower blood pressure.[11]

- Children with asthma who were treated by a collaborative team had fewer days per year of symptoms than children in standard care.[12]

- Alzheimer's patients receiving collaborative care had significantly fewer psychological symptoms of dementia at 12 and 18 months, without increasing their medication.[5]

- Terminally ill patients receiving team-managed, home-based primary health care reported significant improvements in factors such as their level of pain and mental health.[13]

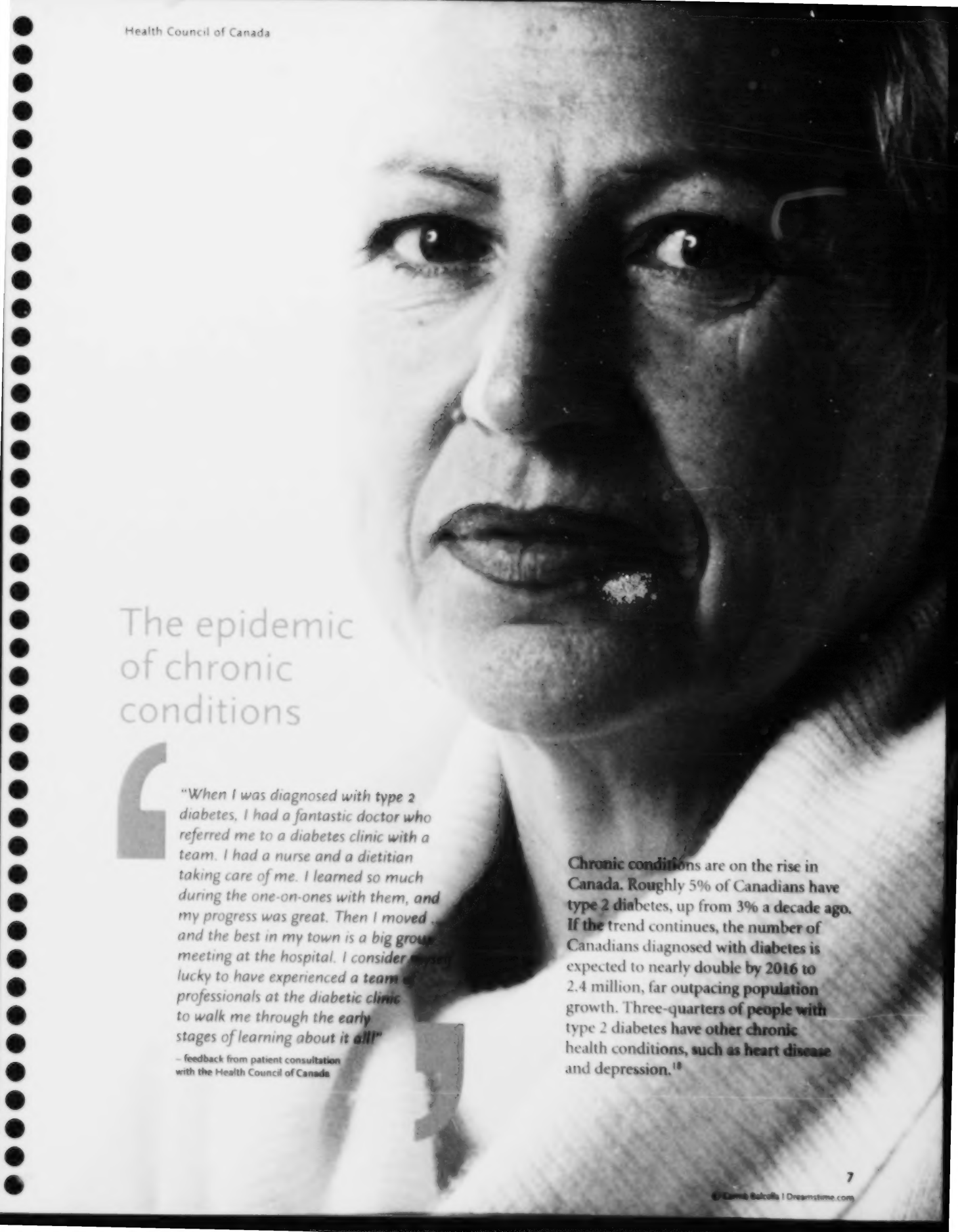
- A review of studies of patients with heart disease showed that those who received specialized follow-up by a multidisciplinary team were less likely to be hospitalized than those who did not receive this type of follow-up.[8]



- Overweight patients being treated by a multi-disciplinary group were more likely to achieve their weight-loss goals than those in other treatment groups.[14]

It's important to note that the existence of a team alone isn't enough to make a difference.

In order for patients to benefit, teams must have the right mix of skills and health disciplines; team members need to communicate and collaborate well, with clear objectives; and they need to provide top-quality care to patients.[15, 16, 17]



The epidemic of chronic conditions

"When I was diagnosed with type 2 diabetes, I had a fantastic doctor who referred me to a diabetes clinic with a team. I had a nurse and a dietitian taking care of me. I learned so much during the one-on-ones with them, and my progress was great. Then I moved [illegible] and the best in my town is a big group meeting at the hospital. I consider myself lucky to have experienced a team of professionals at the diabetic clinic to walk me through the early stages of learning about it all!"

– feedback from patient consultation with the Health Council of Canada

Chronic conditions are on the rise in Canada. Roughly 5% of Canadians have type 2 diabetes, up from 3% a decade ago. If the trend continues, the number of Canadians diagnosed with diabetes is expected to nearly double by 2016 to 2.4 million, far outpacing population growth. Three-quarters of people with type 2 diabetes have other chronic health conditions, such as heart disease and depression.[10]

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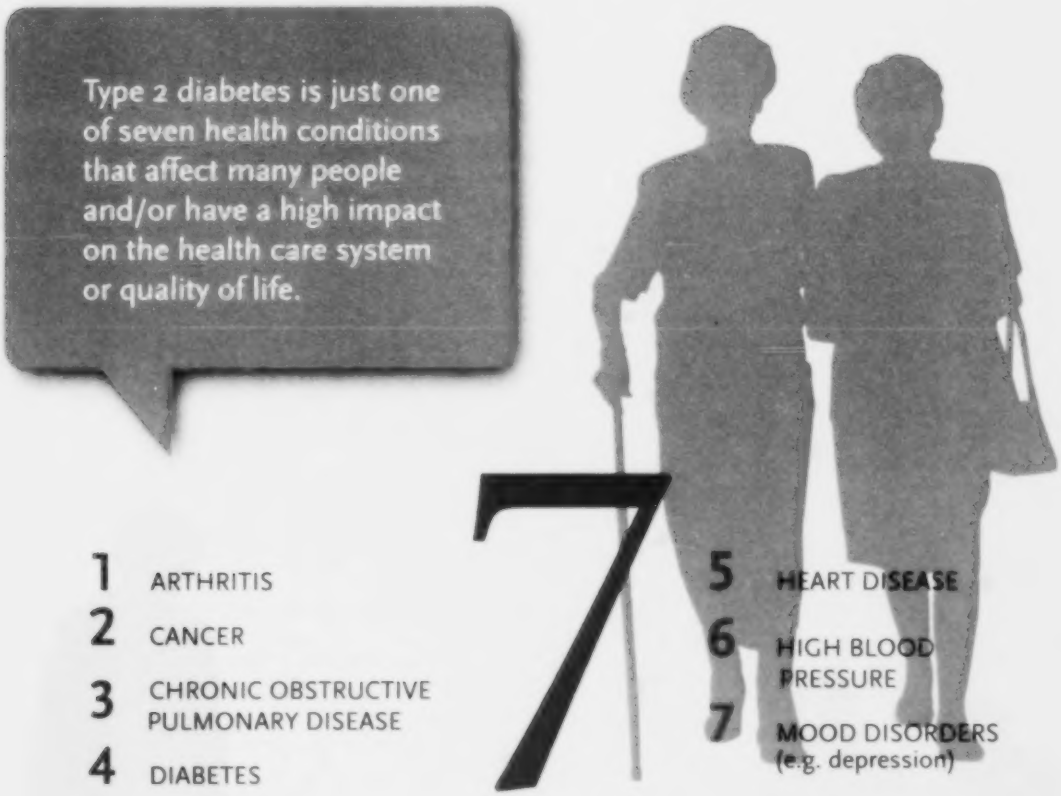
At least one in three Canadian adults—more than nine million people—has one or more of these chronic conditions, and the numbers are growing.[9]

People with chronic conditions often struggle with complications and diminished health, and they require many health care services. One-third of Canadians with a high-impact chronic condition uses 51% of all visits to family doctors, 35% of visits to specialists, and 72% of nights spent in hospitals.[10]

That's why teams have such value. Research shows that helping patients manage their chronic conditions more effectively can make a significant difference to their health.[11] Teams of health professionals work together with the patient to develop a plan for his or her chronic disease management and coordinate the services he or she receives. Many teams targeted to chronic disease management have a strong focus on patient education and health promotion, helping patients better manage their existing conditions by improving lifestyle factors such as diet and exercise.



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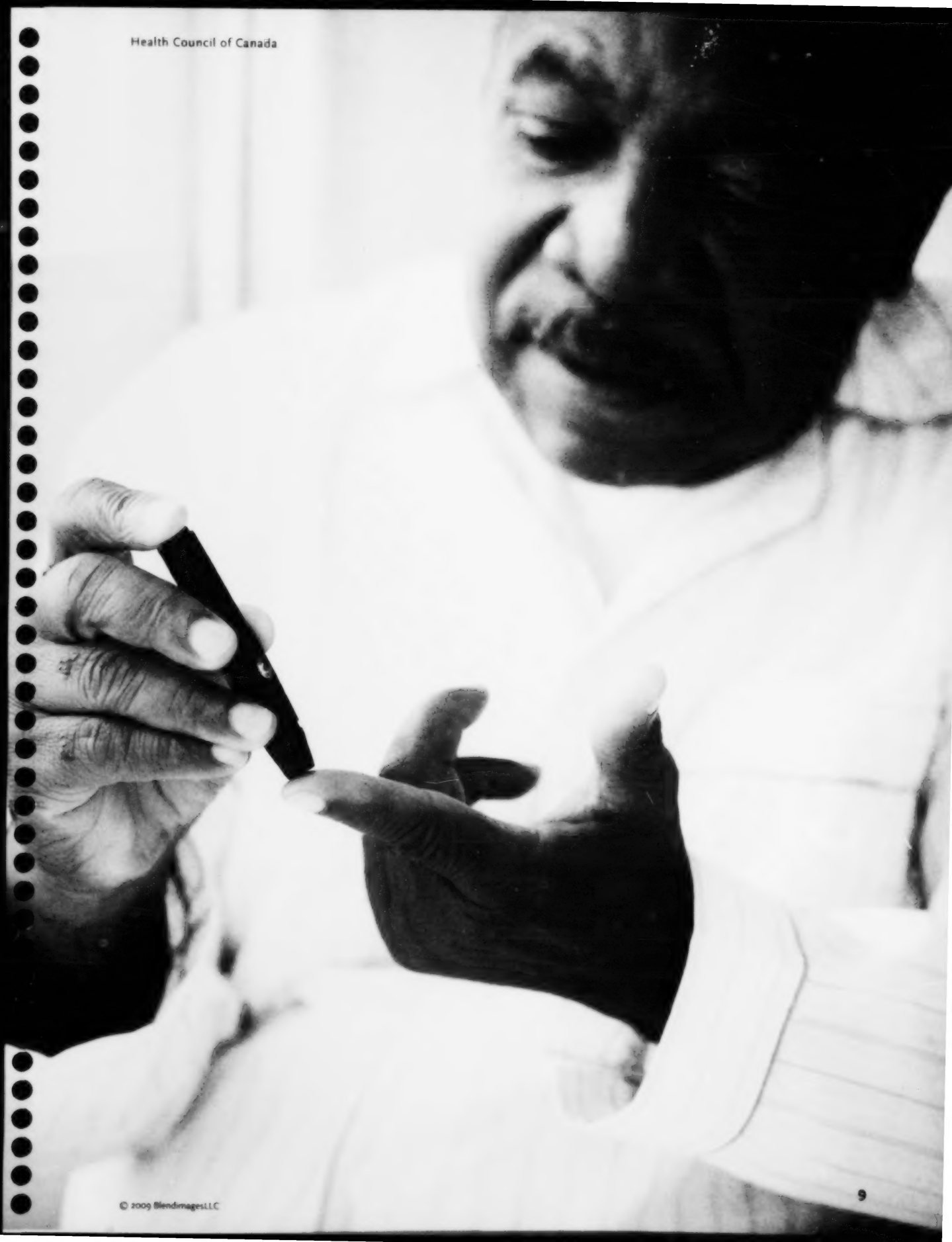
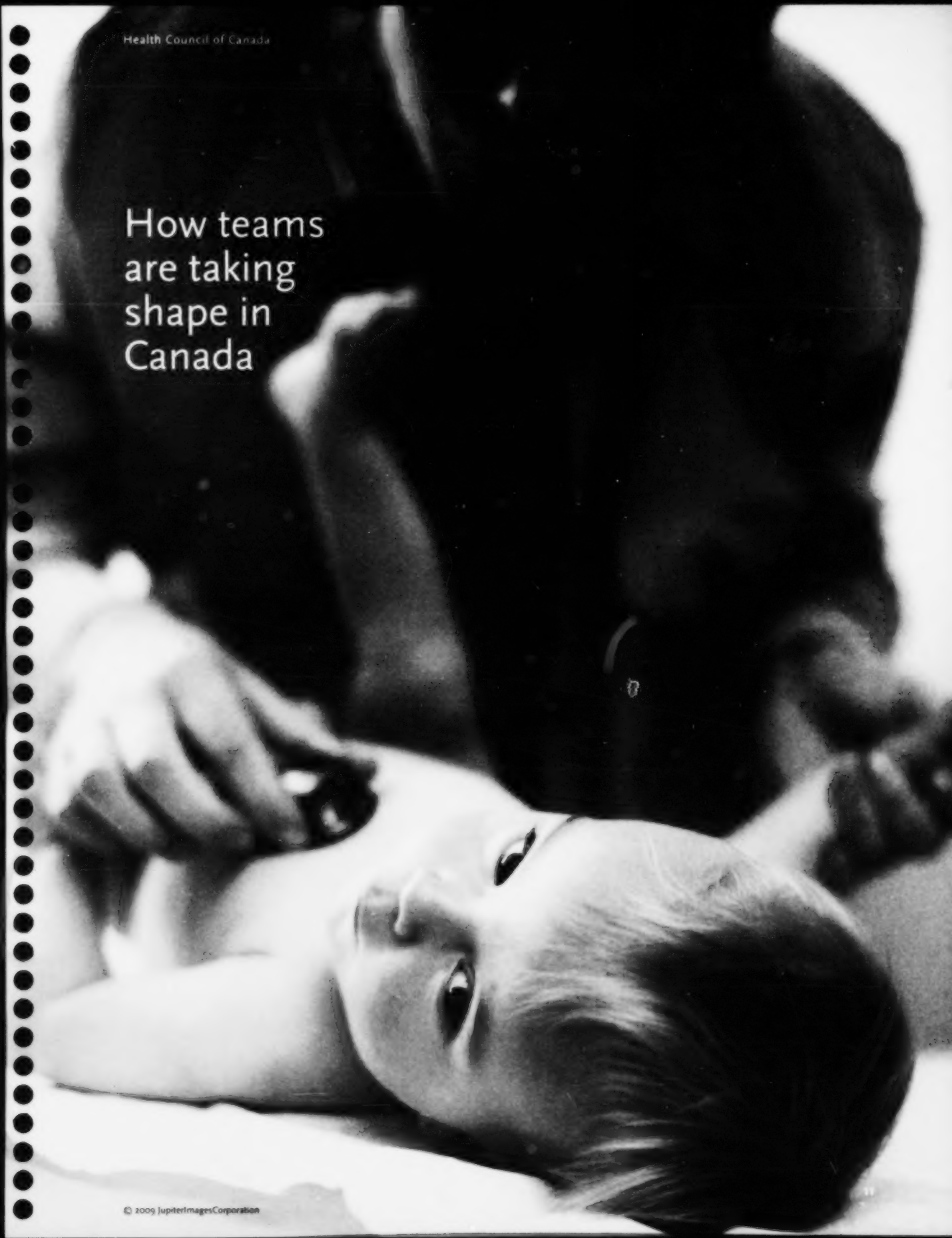



In 2004, governments committed to providing 50% of Canadians with primary health care teams by 2011.
Where are we now?

How teams are taking shape in Canada



HOW TEAMS ARE TAKING SHAPE IN CANADA

Primary health care teams have really only started to expand across Canada within the last decade, the result of a push to improve primary health care. Millions of dollars have been earmarked to support these changes. (Details can be found in *What governments promised* and *A history of teams in Canada* on page 50.) Governments recognized the growing challenge of managing and preventing chronic conditions, particularly with an aging population. They encouraged the development of teams of health professionals to deliver primary health care with a particular focus on improving the care of chronic conditions, promoting health, and preventing disease.[20]

In 2004, as part of the *10-Year Plan to Strengthen Health Care*, the federal government and all the provinces and territories* committed to ensuring that 50% of Canadians have access to multidisciplinary teams for primary health care by 2011.[21]

To learn how teams are taking shape across Canada, we interviewed government officials in participating provinces and territories as well as the federal government (which provides primary health care services to certain populations).

The *10-Year Plan to Strengthen Health Care* states that jurisdictions will increase their use of teams, but it doesn't define what a team should look like, how it should work, or what it should do.

As a result, each jurisdiction has the flexibility to develop team-based care that meets the specific needs of its population. The results are interesting, varied, and promising. Teams look quite different across the country, and they work differently, too. They are tailored specifically to meet the needs of their region or populations.

In one region, a team may be a dozen health professionals working in different locations but in frequent contact to plan and monitor their patients' care. In another, it could mean a paramedic and nurse working together in a mobile primary health care clinic, located in a converted bus.

As expected, many jurisdictions use teams in rural and remote regions and to provide after-hours access to care. Every jurisdiction has designed teams to manage chronic diseases such as diabetes and heart disease, often with innovative approaches. In addition, there is clearly a significant level of commitment and creativity in using teams to address specific regional needs, particularly reaching out to vulnerable or high-risk populations struggling with problems such as poverty and language or cultural barriers. In some cases, teams have been structured to play a role beyond medical care and health promotion; they also serve as community catalysts for change, working to improve their communities and reducing the factors that put their patients at risk.

*Quebec agreed to the overall objectives but committed to developing its own plan.

The Health Council of Canada has also produced five in-depth case studies of successful teams, four in Canada and one in Finland, available at **www.healthcouncilcanada.ca.**

A cross-Canada view of teams begins on page 24. Read *Teams in action* and learn how your province or territory is choosing to use team-based primary health care.

WHAT MAKES A TEAM?

A collaborative team is more than just two or more health care professionals working together. What matters most is whether the team has the right mix of professionals for the patients it serves, how well team members collaborate, and how this ultimately benefits their patients.

A good team works together to solve or explore common issues, with the best possible participation of the patient. There is shared planning, decision-making, and a willingness to participate. And although team members have well-defined and distinct roles, and may even be employed by different organizations, they share an identity as a working team and a responsibility for achieving common goals.[22, 23, 24]

We don't know how many teams in Canada are meeting this ideal. Several jurisdictions shared examples of teams that have taken to the concept of collaborative practice from the start. But jurisdictions have also said that some health care professionals have more difficulty than others moving from a traditional hierarchy of professional roles and responsibilities to working with other disciplines in a more collaborative style. The success of their teams, said several jurisdictions, has depended on the willing participation, cooperation, and ongoing commitment of its members, a finding confirmed by studies.[17, 24, 25] Some jurisdictions also spoke of the need to educate the public and help people become comfortable with seeing health professionals other than a doctor.

Research shows that working in a primary health care team also has advantages for health care professionals. A number of studies confirm that professionals who work in a team are more satisfied and have a more positive work experience than those who don't practise in these settings. Team members develop greater knowledge and skills and a more positive perception of working collaboratively with other professionals.[1]

Are teams good value for money?

Will teams improve the health of Canadians and, in doing so, save money in the health care system? The theory is that although team-based care can be more expensive than a doctor alone, the increased health promotion and chronic disease management that teams provide will improve people's health and therefore reduce their use of other health services, including costly hospitalizations.[26, 27]

There are no answers yet. Although some research shows that team-based care may lead to fewer doctor and emergency department visits, fewer hospitalizations, and fewer medications per patient,[1] there is still not much system-wide information on the cost benefits of team-based care. This is an area that governments need to look at more closely.

FAMILY DOCTORS SUPPORT TEAM CARE

The College of Family Physicians of Canada, which represents family doctors, has issued a formal statement in support of team-based care.

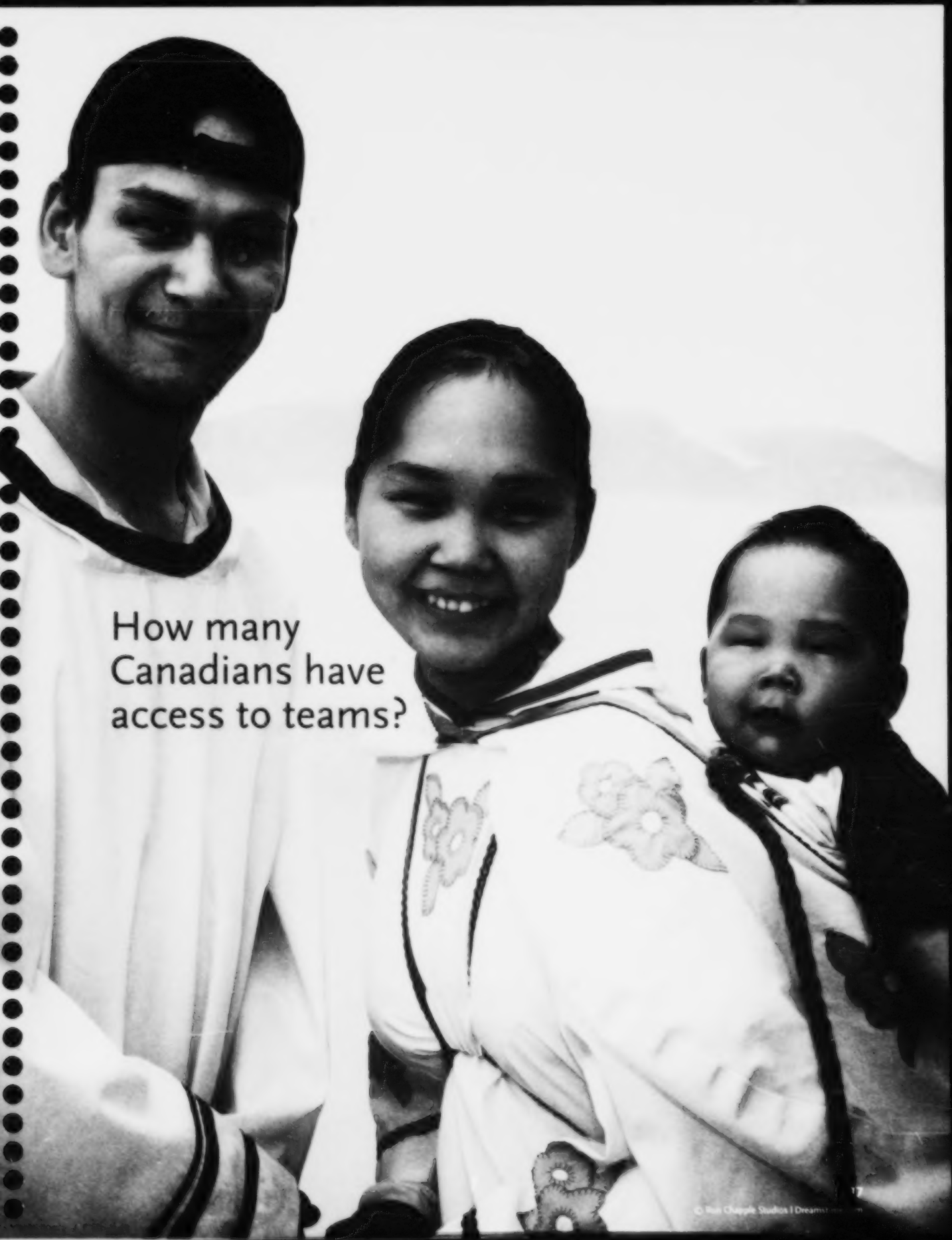
The organization stated that it believes "when family physicians and registered nurses bring their skills together, there is significant potential to increase access and to reduce waiting times for patients with benefits to the whole system."

The College expressed a commitment to look at how team-based care could be put in place across the country.[28]

OTHER HEALTH PROFESSIONALS ALSO SUPPORT TEAMS

A partnership between 10 national associations of health care disciplines and a health care coalition took the lead to investigate the best ways for health care professionals to work together to improve the health results of their patients.

The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative represented physicians, nurses, social workers, physiotherapists, speech-language pathologists, audiologists, dietitians, psychologists, pharmacists, occupational therapists, and one national coalition on preventive practices. The EICP collected examples of successful primary health care in both urban and rural settings, assessed successful team practices across Canada, and provided information on ways to encourage collaboration.[19]


How many
Canadians have
access to teams?

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HOW MANY CANADIANS HAVE ACCESS TO TEAMS?

We're unable to report how many Canadians are experiencing team-based care. Not all governments are gathering this information in a consistent way. In addition, jurisdictions define and use teams differently, and this is reflected in the percentage of their population that is covered by team-based care.

However, two national surveys provide some clues about Canadians' access to health care teams: the 2007 National Physician Survey, and the 2008 Canadian Survey of Experiences with Primary Health Care, co-funded by the Health Council of Canada and the Canadian Institute for Health Information.

In the 2007 National Physician Survey, nearly one-third (31%) of family doctors reported that they had a formal arrangement to collaborate with nurses. Half of these doctors reported that they worked with highly specialized nurse practitioners and/or psychiatric nurses. Family doctors also reported that they worked with dietitians or nutritionists (14%), social workers (13%), physiotherapists (12%), pharmacists (11%), occupational therapists (11%), mental health counsellors (10%), or psychologists (10%). Younger family doctors were more likely than older doctors to work in team settings.[30]

In the 2008 Canadian Survey of Experiences with Primary Health Care, one-third (32%) of Canadian adults reported that they had access to more than one primary health care provider, meaning that they said a nurse worked with their doctor* and was involved in their care (16%), that another health professional worked in the same office as their doctor (10%), or both (6%).[5] (See pie chart on next page.)

*A small percentage of these respondents did not have a regular medical doctor but said they had a regular place of care, such as a clinic.

Whether these people are receiving team-based care is unclear (for example, two professionals working in the same office does not necessarily mean they are a collaborative team), but results did show that these respondents had several advantages over those who saw only one primary health care provider.

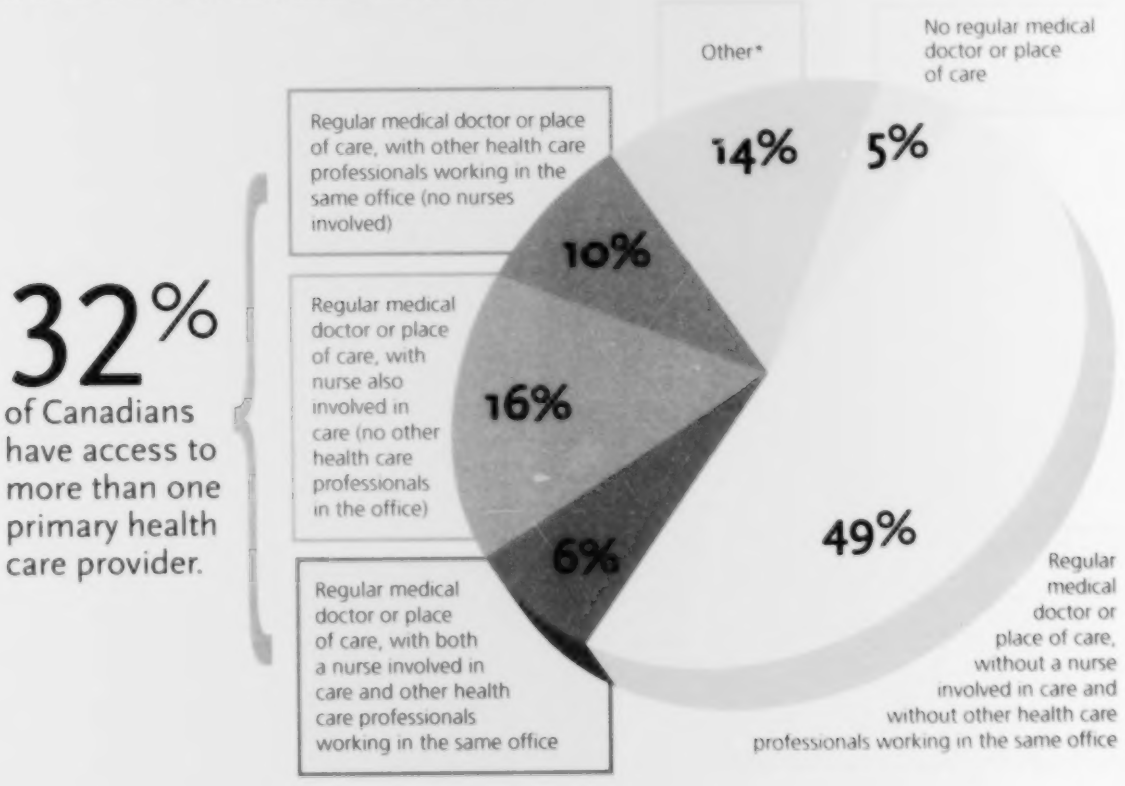
Canadians who had additional access to either a nurse and/or other health care professionals were:

- more than 2.5 times more likely to report that their health care provider(s) provided a range of services that met most of their needs;
- 42% more likely to rate the quality of the health care they received as good, very good, or excellent, compared to those with access to one provider; and
- 46% more likely to report that they had more knowledge about their conditions and 67% more likely to report that they know how to prevent future problems.

Adults with one chronic health condition were 41% more likely to report that they had access to more than one primary health care professional (such as both a doctor and a nurse or dietitian), compared with those with no long-term health problems. Adults with two or more chronic conditions were 52% more likely to say this.[3]

These findings indicate that people with chronic health conditions and more extensive health needs are seeing more health professionals than the general population. Unfortunately, the data can't tell us if they're seeing the most appropriate mix of professionals or whether those professionals work as a collaborative team.

One-third of Canadians have access to more than one primary health care provider



***Refusals and responses that did not fit into other categories**
"Other health care professionals" means providers other than doctors or nurses, such as dietitians
Source: 2008 Canadian Survey of Experiences with Primary Health Care

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Canadians who had additional access to either a nurse and/or other health care professionals were:

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"Other health care professionals" means providers other than doctors or nurses, such as dietitians
Source: 2008 Canadian Survey of Experiences with Primary Health Care


Do you
need a team?

Nearly three-quarters of Canadians strongly support the idea of teams, and would prefer that their family doctor work as part of a team.

As mentioned earlier, research shows that teams are particularly helpful for preventing and treating chronic diseases, for treating mental health issues such as depression, and for providing care to specific populations. But there is little research clearly indicating the impact of teams on general primary health care delivery.[1]

More research is needed before any conclusions can be reached about the value of teams for the general population.

Nevertheless, Canadians like the idea of teams. Nearly three-quarters (70%) of Canadians strongly support the idea of a team that collaboratively provides care,[31] and a similar number (74%) would prefer that their family doctor work as part of a team, rather than practise on his or her own.[32] Canadians also like the idea that primary health care teams offer an increased focus on wellness, prevention, and patient education.[33]

However, one in five (20%) of Canadians said they would not be satisfied seeing a nurse rather than their doctor for routine health care services such as ear infections or immunizations, to manage diabetes, or to monitor high blood pressure.[32] This research was done in 2002, and some jurisdictions confirmed that there continues to be some public resistance to seeing health professionals other than a doctor. They said it is important to educate the community about team care in order to gain acceptance.

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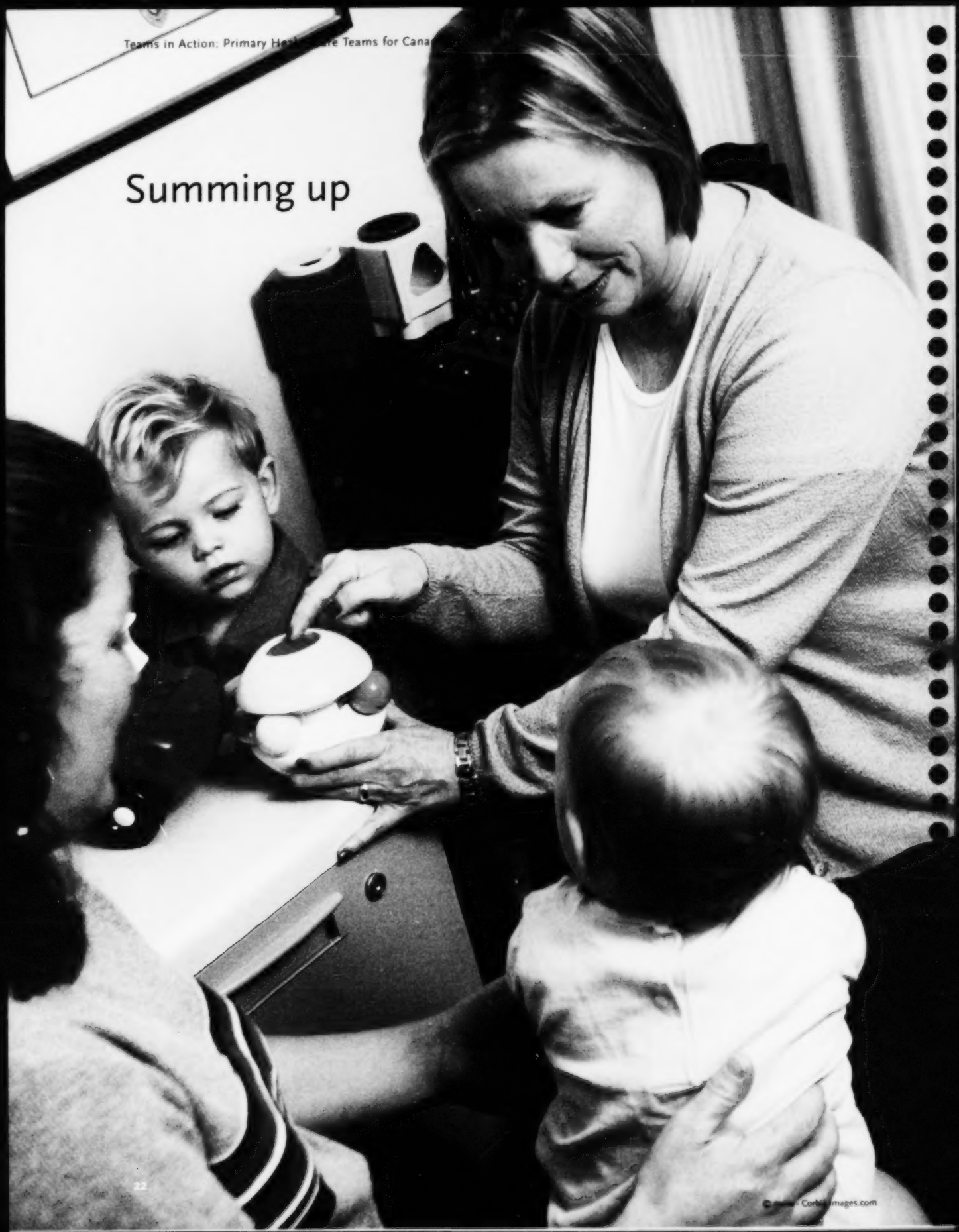
Summing up



CONCLUSIONS

There has been a significant push in funding and efforts in the last decade to expand the use of teams in primary health care, but team-based primary health care is still evolving in Canada. Each jurisdiction has made a good start. They are largely tailoring their activities towards specific populations and high-needs groups (such as those with chronic conditions), where teams have been shown to make a difference. They are also using teams to provide service to areas that lack enough—or any—family doctors, and to reach out to vulnerable populations that can have difficulty accessing the primary health care they need.

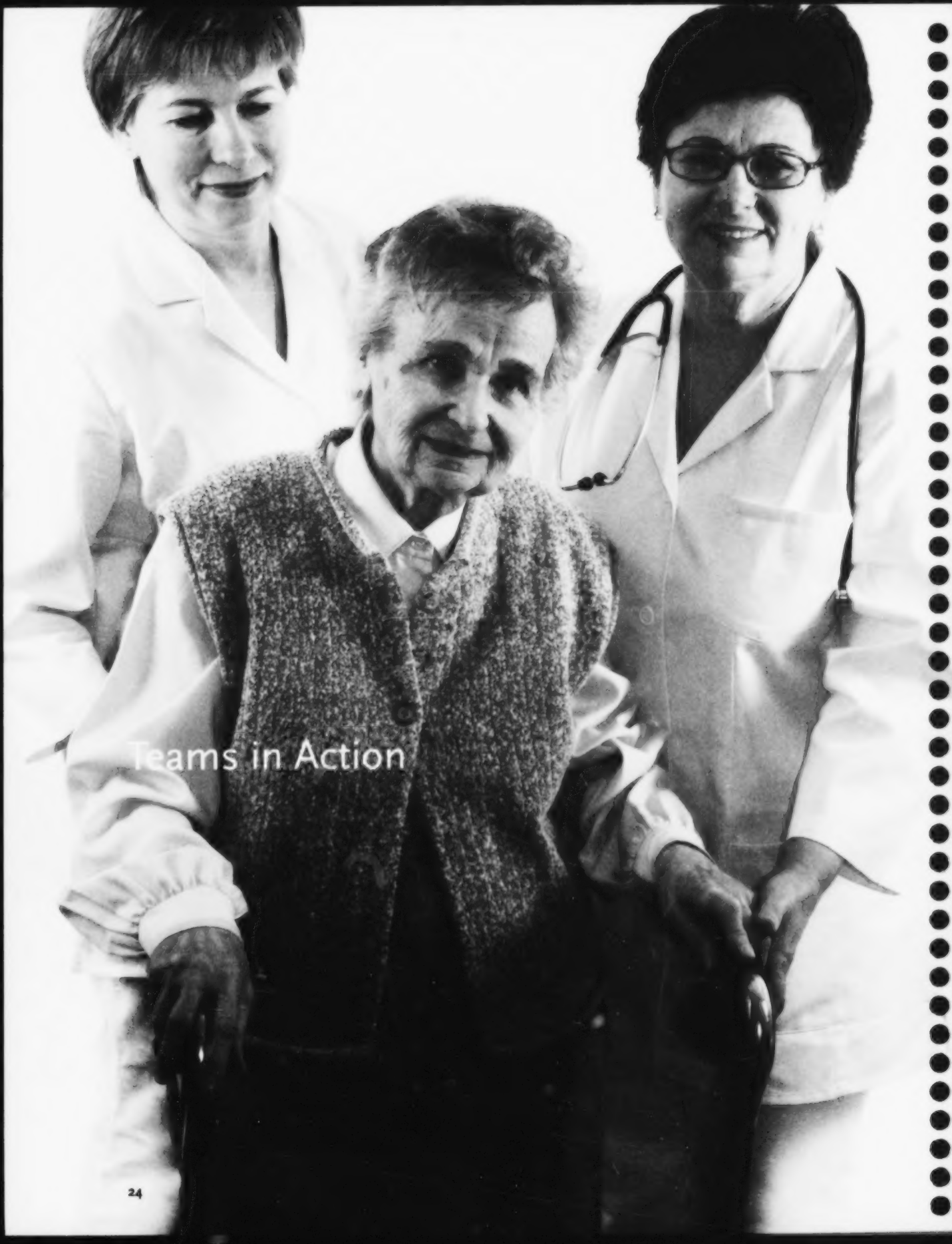
What clearly came through in our interviews with all governments is a strong commitment to implementing team-based care, with a wide range of often-innovative approaches. But there were some significant gaps in the information provided:

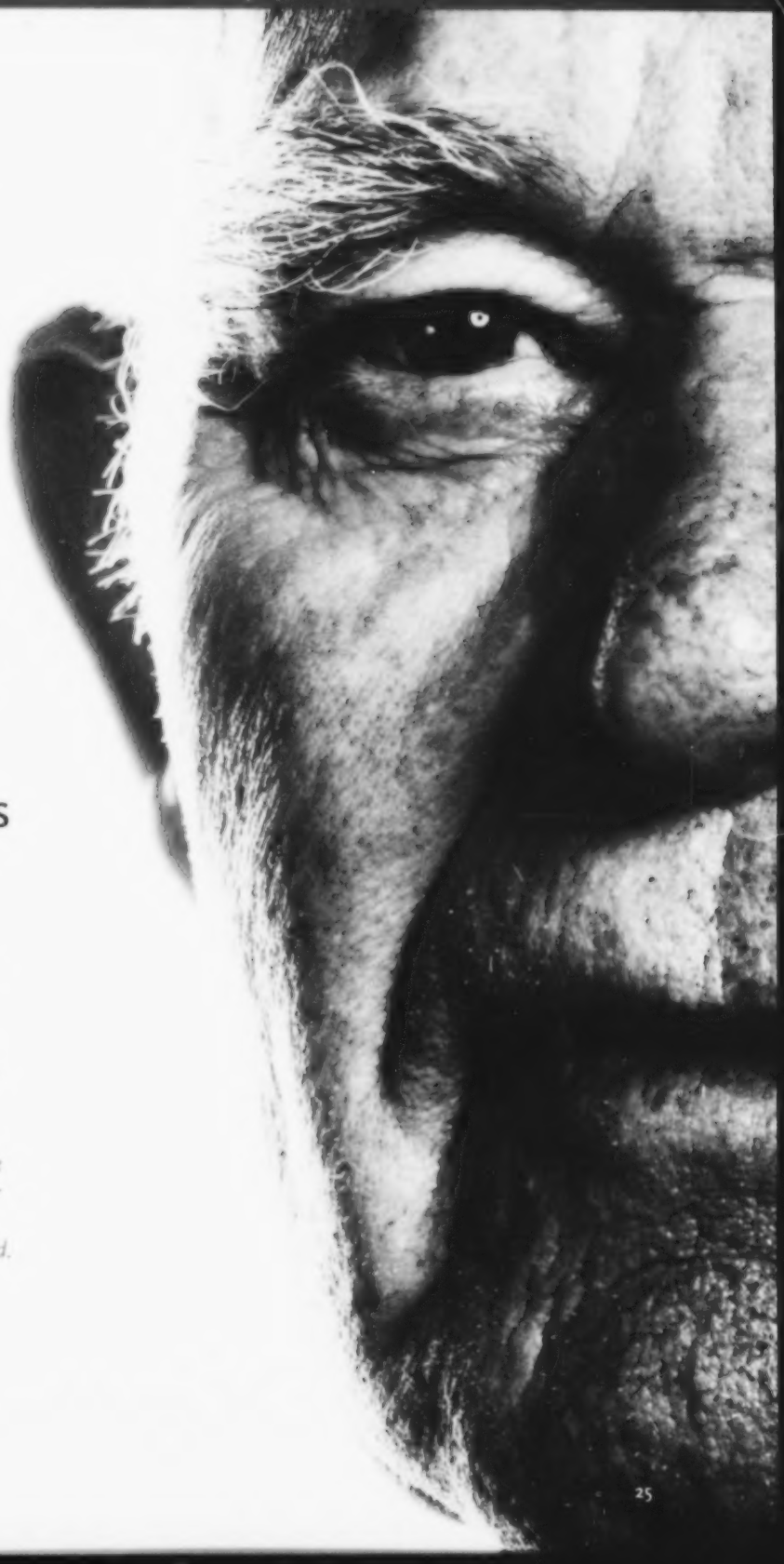
- We're unable to report how many Canadians have access to collaborative teams. Not all jurisdictions are gathering that information in a consistent way. It is unlikely that in two years governments will be able to claim that they have met the target established in 2004: that 50% of Canadians would have access to multidisciplinary teams by 2011. However, since 2004, more evidence has been gathered that shows the value of teams is most significant for specific populations. It may make more sense for governments to focus on expanding team care for those who need it the most. This may or may not represent 50% of their populations.

- Research shows that teams make a difference for people with chronic conditions and mental health issues such as depression, and for other specific populations. Teams are also an effective way to provide primary health care in regions without enough family doctors. Beyond that, do they make a difference for other populations, or for people with relatively uncomplicated health care needs? We don't know—at least, not yet. There currently isn't enough evidence. We urge governments to thoroughly evaluate and commission appropriate research.

- One challenge in evaluating the cross-Canada efforts is that there is no single, clear definition of what makes a truly collaborative team. There are lots of different models of teams in Canada, but little evaluation to tell us how they work together or which mix of health professionals is best for addressing specific health needs.

Ultimately, team-based care has significant potential to improve the health of many Canadians. But governments must make sure that their current efforts are evaluated to determine what types of teams work best, where they offer the greatest benefit to patients, and where they provide the most value for money to the health care system.


Teams in Action



Integrated Health Networks: a new way to care for chronic conditions

Like many people with diabetes, Sam also has heart disease and high blood pressure, and lately he's been feeling anxious and depressed. Sam likes his family doctor, who manages a lot of his care, but he's frustrated with the time it takes to get an appointment with specialists. More importantly, he's made three trips to emergency in the past year because of problems that arose late at night, when his doctor's office was closed.

HEALTH CARE MAY SOON BE EASIER FOR SAM (A FICTIONAL CHARACTER) AND OTHERS LIKE HIM IN BRITISH COLUMBIA. HE AND HIS FAMILY DOCTOR HAVE JUST ENROLLED IN ONE OF BC'S NEW INTEGRATED HEALTH NETWORKS. LOCATED THROUGHOUT THE PROVINCE, THE NETWORKS ARE DESIGNED TO IMPROVE ACCESS TO CARE FOR PATIENTS WITH COMPLEX CHRONIC CONDITIONS AND TO BETTER COORDINATE THE WORK OF THE MULTIPLE HEALTH CARE PROVIDERS AND COMMUNITY RESOURCES THAT PEOPLE LIKE SAM CAN BENEFIT FROM. IN PARTNERSHIP WITH REGIONAL HEALTH AUTHORITIES AND THE BC MEDICAL ASSOCIATION, THE PROVINCE LAUNCHED 26 INTEGRATED HEALTH NETWORKS IN NOVEMBER 2008.

Another goal of the Integrated Health Networks is to improve service in under-serviced communities for patients with mental health conditions and addictions, and for the frail elderly. For all of these populations, planned and coordinated care and access to the right kind of provider will result in fewer trips to emergency and more potential problems prevented.

How do Integrated Health Networks work? Once enrolled through their doctor, patients and their families are recognized as part of a team that, depending on each patient's needs, may include nurses, dietitians, pharmacists, specialist physicians, mental health services and home care. The family doctor leads the team in creating a "care plan" for each patient. The care plan, which captures the patient's personal goals, becomes a guide for all team members. The goal is to help Sam stay on top of his conditions, and to provide care that is continual, coordinated, and comprehensive.

BC hopes that, within the year, close to 600 physicians and 50,000 patients will be enrolled in the 26 networks. For the health care system, the shift should eventually mean lower average costs per patient. Evaluation of other BC primary health care initiatives are already showing a decline in hospital costs related to complex patients who have a long-term relationship with their family physician.

In addition, patients in an Integrated Health Network can expect fewer repetitions of their medical history and tests, because all their health care providers are communicating with one another directly. And patients can expect to have more knowledge and ability to manage their own conditions, because their team of providers is focused on working together to help patients stay as well as possible. Patients have access to self-management training delivered by peers in their community.

To chart the province's progress towards these goals, BC is undertaking a major evaluation of the Integrated Health Networks. The study will collect data on the outcomes of care, such as whether patients go back to hospital for the same condition, and will ask patients and health care providers about their experiences with the new model of care. The first evaluation results are expected in 2010.

To learn more about team-based primary health care in British Columbia, including a map of BC's Integrated Health Networks and their target populations, see our online Backgrounder: www.healthcouncilcanada.ca

QUICK FACTS - BRITISH COLUMBIA

- **Population: 4.4 million**
- **80+ interprofessional primary health care teams**
- **25% of target population served by teams**
- **26 Integrated Health Networks implemented, serving 50,000 people**
- **$500,000 being spent on a system-wide study of the impact of team care**

Mobile bus brings primary health care to lower-income neighbourhoods

When the Saskatoon Health Region was looking into the idea of a mobile health bus to reach out to inner city residents, they asked for advice from community-based organizations in these communities—and what they heard was direct and invaluable.

"Don't fool yourself by thinking 'If you build it, they will come,' because that's not the way these communities work," one advisory committee member told the health region. "They need three things – to feel welcome, to feel safe, and to feel as though they are not being judged."

That philosophy now underpins the work of Saskatoon's new mobile team clinic, called the Health Bus, a converted RV with a fully-equipped examination room. The bus is staffed by teams of a paramedic and a nurse practitioner who provide a range of health services: health checks, blood pressure and blood sugar checks, chronic disease management, wound care, follow-up care, and advice on how to live a healthier lifestyle. The paramedic and nurse practitioner call on local physicians as required, and also link patients to other health and community services.

Those who use the bus include First Nations and Métis people, immigrants, and refugees. Many people from these groups are hesitant to access conventional providers or health care centres. To preserve their confidentiality, and to encourage them to come to the bus for care, patients don't need to show a health card or otherwise identify themselves. Bus staff work to reach out to their patients, making it easy for people to come to them by operating seven days a week, 2 p.m. to 10 p.m., and parking in convenient locations such as outside a McDonald's or in a Walmart parking lot. The flexible hours can be helpful to people who work shifts or are in low-paying day jobs that allow limited time off for appointments.

Started as a pilot project in August 2008, the bus is a partnership between the Saskatoon Health Region and MD Ambulance, a private emergency service in the community. Since then, roughly 1,000 people have visited the bus (approximately eight or nine a day), largely from word-of-mouth advertising.

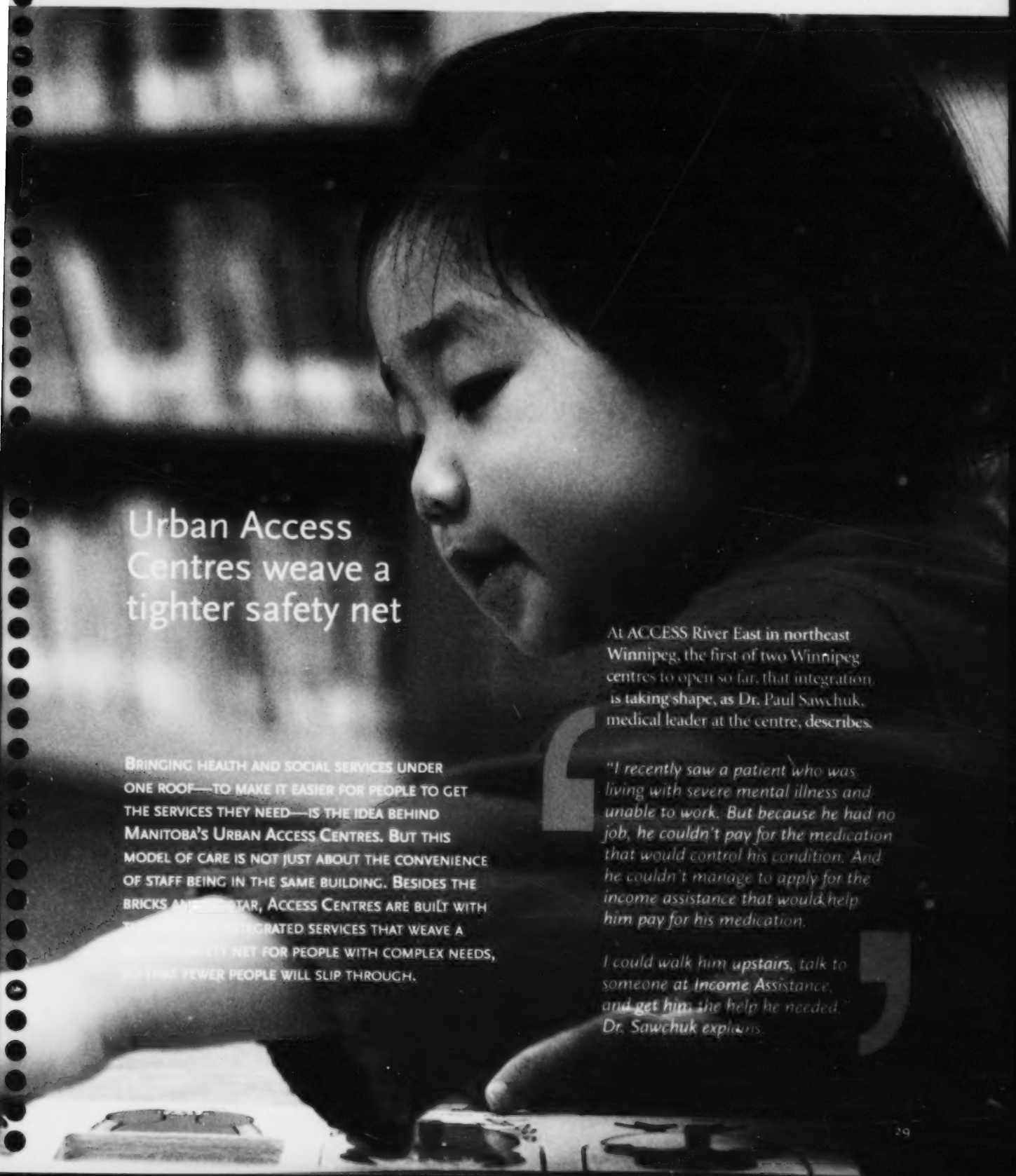
"I think this proves we are gaining trust in the community, one person at a time," said an unnamed staff member in a six-month evaluation report. The report showed that the bus is having a significant impact on patients' health: in particular, staff have been able to identify a number of undiagnosed chronic conditions such as diabetes and high blood pressure, and have made arrangements for patients to be seen for assessment and treatment.

In response to these promising results, Saskatchewan Health recently approved the bus as an annually funded program.

The Health Bus is just one of the new primary health care teams implemented in Saskatchewan in the last few years, each one established after a community review to make sure that the team is designed to meet the specific needs of the population. For more information about other teams in Saskatchewan, see our online backgrounder www.healthcouncilcanada.ca

QUICK FACTS - SASKATCHEWAN

- **Population: 1 million**
- **61 primary health care teams**
- **29% of residents have access to teams**



Urban Access Centres weave a tighter safety net

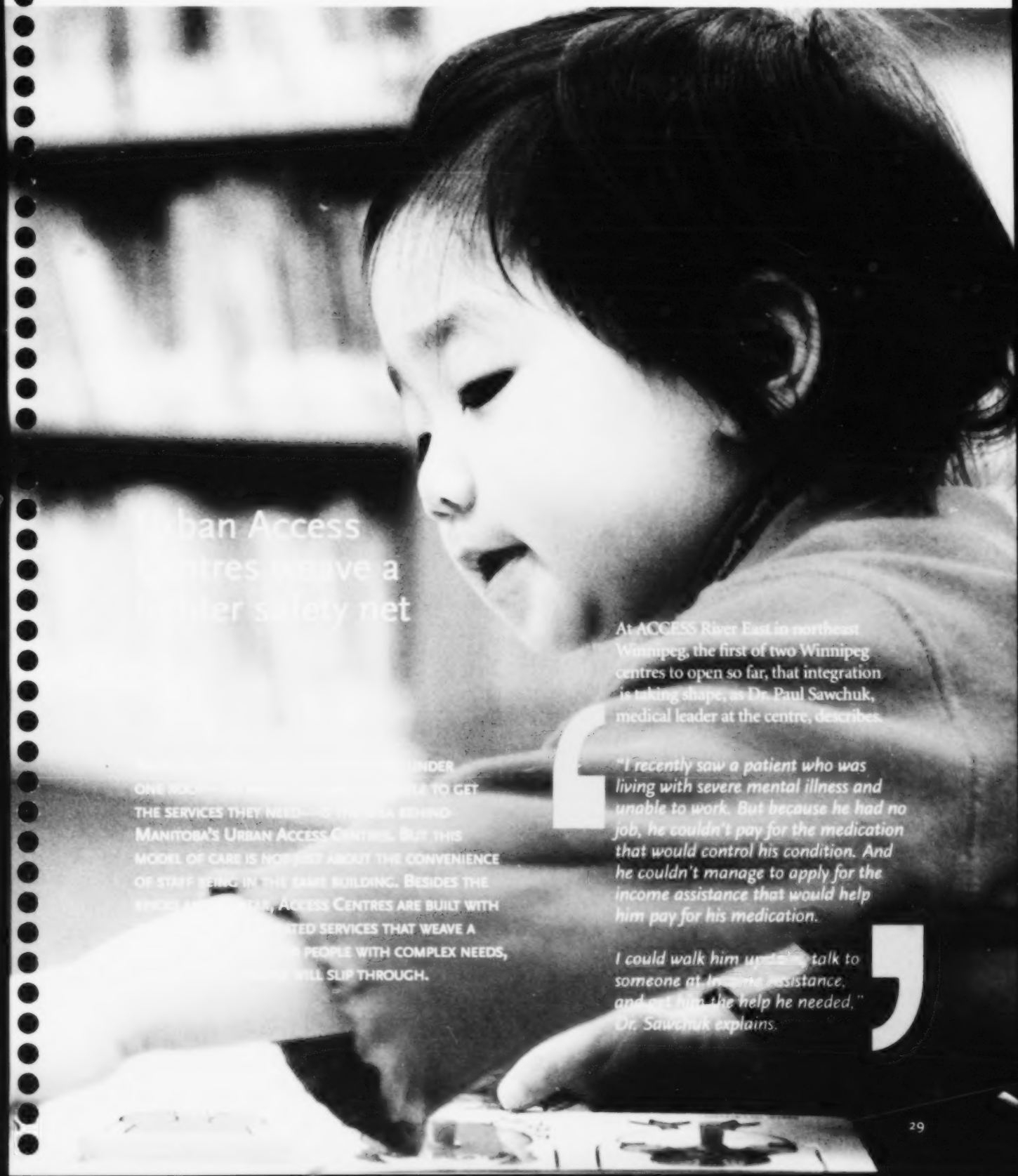
BRINGING HEALTH AND SOCIAL SERVICES UNDER ONE ROOF—TO MAKE IT EASIER FOR PEOPLE TO GET THE SERVICES THEY NEED—IS THE IDEA BEHIND MANITOBA'S URBAN ACCESS CENTRES. BUT THIS MODEL OF CARE IS NOT JUST ABOUT THE CONVENIENCE OF STAFF BEING IN THE SAME BUILDING. BESIDES THE BRICKS AND MORTAR, ACCESS CENTRES ARE BUILT WITH INTEGRATED SERVICES THAT WEAVE A SAFETY NET FOR PEOPLE WITH COMPLEX NEEDS, SO THAT FEWER PEOPLE WILL SLIP THROUGH.

At ACCESS River East in northeast Winnipeg, the first of two Winnipeg centres to open so far, that integration is taking shape, as Dr. Paul Sawchuk, medical leader at the centre, describes.

"I recently saw a patient who was living with severe mental illness and unable to work. But because he had no job, he couldn't pay for the medication that would control his condition. And he couldn't manage to apply for the income assistance that would help him pay for his medication.

I could walk him upstairs, talk to someone at Income Assistance, and get him the help he needed," Dr. Sawchuk explains.

Teams in Action: Manitoba



Urban Access Centres weave a better safety net

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The scale of things at ACCESS River East says a lot about what it takes to make urban communities healthier. Debra Vanance, director of the River East centre and another in neighbouring Transcona, oversees more than 750 staff between the two locations, serving 125,000 residents. That's a community larger than many Canadian cities. ACCESS River East serves a cluster of neighbourhoods that includes the highest concentration of seniors in Winnipeg.

The new two-storey centre is home to staff from 12 different programs run by Winnipeg Regional Health Authority and the provincial department of Family Services and Housing, here collaborating as Winnipeg Integrated Services, a new model of providing community care and support. The 12 programs are primary health care, home care, public health, child day care (licensing and coordination), children's special services, community development, mental health, vocational rehabilitation, employment and income assistance, midwifery, seniors' health, and supported living.

Integrating such a rich array of services has opened doors to some creative and productive partnerships with community agencies outside of the centre walls, such as schools, churches, doctors' clinics, seniors' groups, and the local hospital, Vanance says.

"For example, we license child care centres in the area, and because we also have health services staff in our responsibility, we have had speech-language pathologists working with child care providers on literacy for children."

The primary health care team at ACCESS River East includes family doctors, nurse practitioners (who, at this clinic, have their own patients and do most of the things family doctors do), primary care nurses (who focus on health promotion, preventive screening, and chronic disease management), midwives, shared-care mental health counselors, dietitians, and more.

"We are set up to serve the hard-to-serve," says Vanance. "Our priority population in primary health care is people without family doctors and people with very complex needs." Some of the centre's clients are people who have difficulties navigating the system themselves as a result of challenging health conditions and/or social situations, and who would previously have been seen regularly in a hospital emergency.

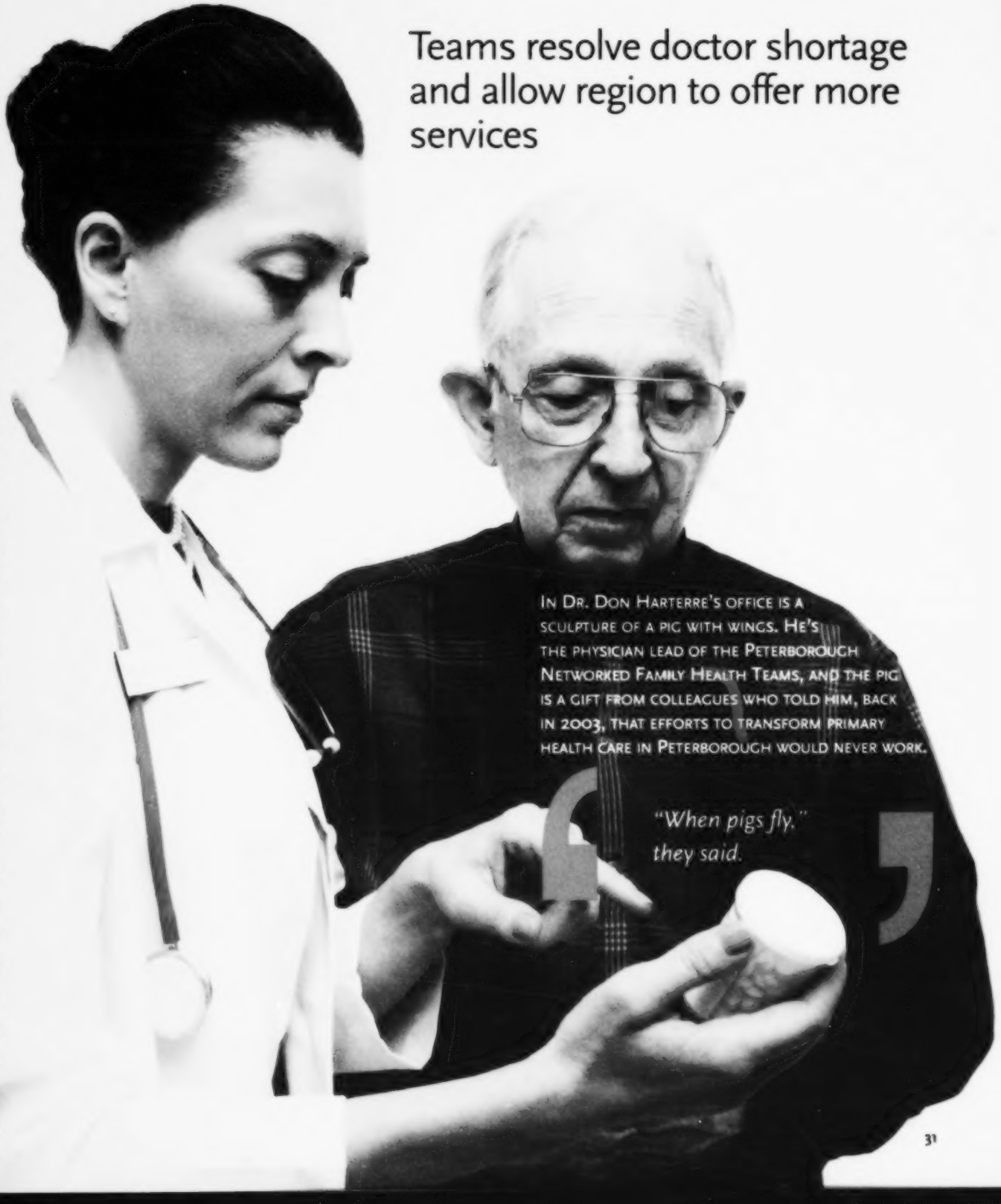
Since ACCESS River East opened in 2004, Manitoba has launched three Urban Access Centres—two in Winnipeg and one in Brandon—and plans are underway for several more in Winnipeg.

Family doctors in Manitoba are signing up to join the Physician Integrated Network (PIN), an initiative designed to improve access to collaborative care for people with chronic health conditions. To learn more about PIN and other features of primary health care teams in Manitoba, see our online background: www.healthcouncilcanada.ca

QUICK FACTS - MANITOBA

- **Population: 1.2 million**
- **9% of family doctors have joined the Physician Integrated Network**
- **65 more family doctors are being recruited to join the Physician Integrated Network in early 2009**

Teams resolve doctor shortage and allow region to offer more services



In Dr. Don Harterre's office is a sculpture of a pig with wings. He's the physician lead of the Peterborough Networked Family Health Teams, and the pig is a gift from colleagues who told him, back in 2003, that efforts to transform primary health care in Peterborough would never work.

"When pigs fly," they said.

Six years ago, Peterborough had a significant shortage of family doctors, and 27,000 patients did not have one. As a result, the local hospital had the busiest single-site emergency department in the province. In addition, Peterborough has an older population, which means physicians were seeing more patients with chronic conditions, who needed additional time and care. The community was struggling to cope. Clearly changes were needed.

The answer was shifting from doctor-based care to providing primary health care through teams of health professionals. There was resistance to the idea among doctors and the public, but Dr. Harterre and his colleagues believed in the value of teams, and the need for them. They spent more than two years patiently and steadily building support for their proposal, listening to ideas and objections and adjusting the plan as needed.

The result was that all the region's family doctors now belong to family health teams, and 17,000 patients now have primary health care that they didn't have before. Visits to the local hospital's emergency department have declined by 15,000. In addition, 16 new family physicians have joined the community, attracted by the innovation and flexibility of the team-based model.

Moving to team-based care has allowed Peterborough to provide some progressive services and clinics. One is a medication reconciliation program, through which team pharmacists provide a prescription drug review for patients who've recently been hospitalized or seen a heart or kidney specialist. This important step helps reduce problems with medication, which are not uncommon after prescriptions have been added or changed by a specialist or during a hospital stay.

Another program is the anticoagulation (blood thinner) monitoring program. People on high-risk blood thinning medication need to be monitored regularly as the dose they need can be affected by factors such as other medications, diet, and level of activity. Too low a dose leaves the patient at risk for a blood clot and resulting stroke; too high a dose can result in excessive bleeding.

Testing normally involves the patient visiting a busy blood lab, having blood drawn, then waiting for the doctor to get the results and call with any changes in the medication dose. This can take several days. But in Peterborough, patients can now visit a convenient one-stop monitoring clinic where a pharmacist uses a finger-prick blood test with immediate results. The pharmacist adjusts the medication dose right then and sends results electronically to the patient's doctor. The clinic also provides advice on drug interactions, the importance of taking medication appropriately and eating a healthy but consistent diet, and the impact of activity levels.

The finger-prick program is used throughout Europe and the US, but Peterborough is one of the first communities in Canada to use it. The results make a significant difference, not only in convenience and reduced discomfort for patients, but in their health. With the traditional method, approximately 55% of patients maintain their medication doses within a safe and effective range. At the specialty anticoagulation clinic, the result is 80%. The Peterborough Networked Family Health Teams hope to receive additional funding in order to expand the program.

To learn more about primary health care teams in Ontario, see our online Backgrounder, www.healthcouncilcanada.ca

QUICK FACTS - ONTARIO

- **Population: 12.9 million**
- **150 Family Health Teams**
- **54 Community Health Centres**
- **16% of residents served by Family Health Teams**
- **18% of primary care physicians work in interdisciplinary models of care including Family Health Teams, Community Health Centres, or Group Health Centre in Sault Ste. Marie**

Improving health by improving communities

A food purchasing club and anger management program—at the same place you see the doctor? Self-esteem workshops for older women? And an after-school drop-in and tutoring program for teens?

THE ST. JOSEPH'S COMMUNITY HEALTH CENTRE IN SAINT JOHN HAS A MUCH BROADER ROLE THAN TRADITIONAL PRIMARY HEALTH CARE. ALTHOUGH THE HEALTH CENTRE PROVIDES MEDICAL ASSESSMENTS AND TREATMENT, ALONG WITH SUPPORT SERVICES AND EDUCATION ON HEALTHY LIVING, ITS STAFF ALSO HAVE A MANDATE TO TAKE A HOLISTIC APPROACH TO HEALTH CARE. THEIR JOB IS TO DEVELOP PROGRAMS TO TACKLE THE SOCIAL DETERMINANTS OF HEALTH FOR THE PEOPLE THEY SERVE, WHICH MEANS LOOKING AT FACTORS THAT STAND IN THE WAY: POVERTY, SUBSTANDARD HOUSING, A LACK OF SUPPORTIVE SOCIAL NETWORKS, SELF-ESTEEM OR ANGER ISSUES, AND MORE. ALL TEAM MEMBERS—DOCTORS, NURSES, NURSE PRACTITIONERS, SOCIAL WORKERS, DIETITIANS, COMMUNITY DEVELOPERS, AN OCCUPATIONAL THERAPIST, AND A PHARMACIST—HELP TO DEVELOP SOLUTIONS, AND WORK TOWARDS COMMON GOALS.

Saint John is a busy industrial port, containing some of the poorest communities in Canada. St. Joseph's provides services to the city's most vulnerable neighbourhoods, earning particular praise for its work in the Old North End. In 2005, this area had a worsening reputation for drugs, crime, and poverty (three-quarters of residents report annual household incomes of less than $20,000). The neighbourhood also had a younger demographic than other areas of the city, a factor often associated with increased drug use and resulting drug-related crime.

At the request of concerned citizens, the health centre team joined forces with police, a local church, non-profit organizations, and community groups to see what could be done. The community health centre took the role of facilitator, asking neighbourhood residents for their opinions: What do you think is happening? And what would you like to see in your community?

Several key themes emerged. Residents reported a high prevalence of chronic health conditions. They said they were stressed, overwhelmed, isolated by their poverty, and worried about their children and teens. They also felt powerless to change the situation either at a personal or community level.

In particular, there was an alarming sense of hopelessness among teens who were interviewed. This was leaving them vulnerable to a variety of high-risk behaviours, including drugs and crime. But the neighbourhood offered little to them. And although there were stories about individual acts of kindness, there appeared to be little sense of community.

During this time, a community police office was being built to respond to some of the community wishes. Local drug dealers didn't like this and set fire to the building. That act galvanized the community. A new Old North End Community Building was established, hosting not only a police community office but a satellite health centre for St. Joseph's Community Health Centre.

The building also serves as a catalyst for broader community programming. There is a meeting room for community groups, a computer room for people in the neighbourhood to access the Internet, an after-school program, recreation activities such as basketball and running, and other on-site programs for adults and teens. The satellite health centre is popular and busy, serving many people who previously didn't use any primary health care services.

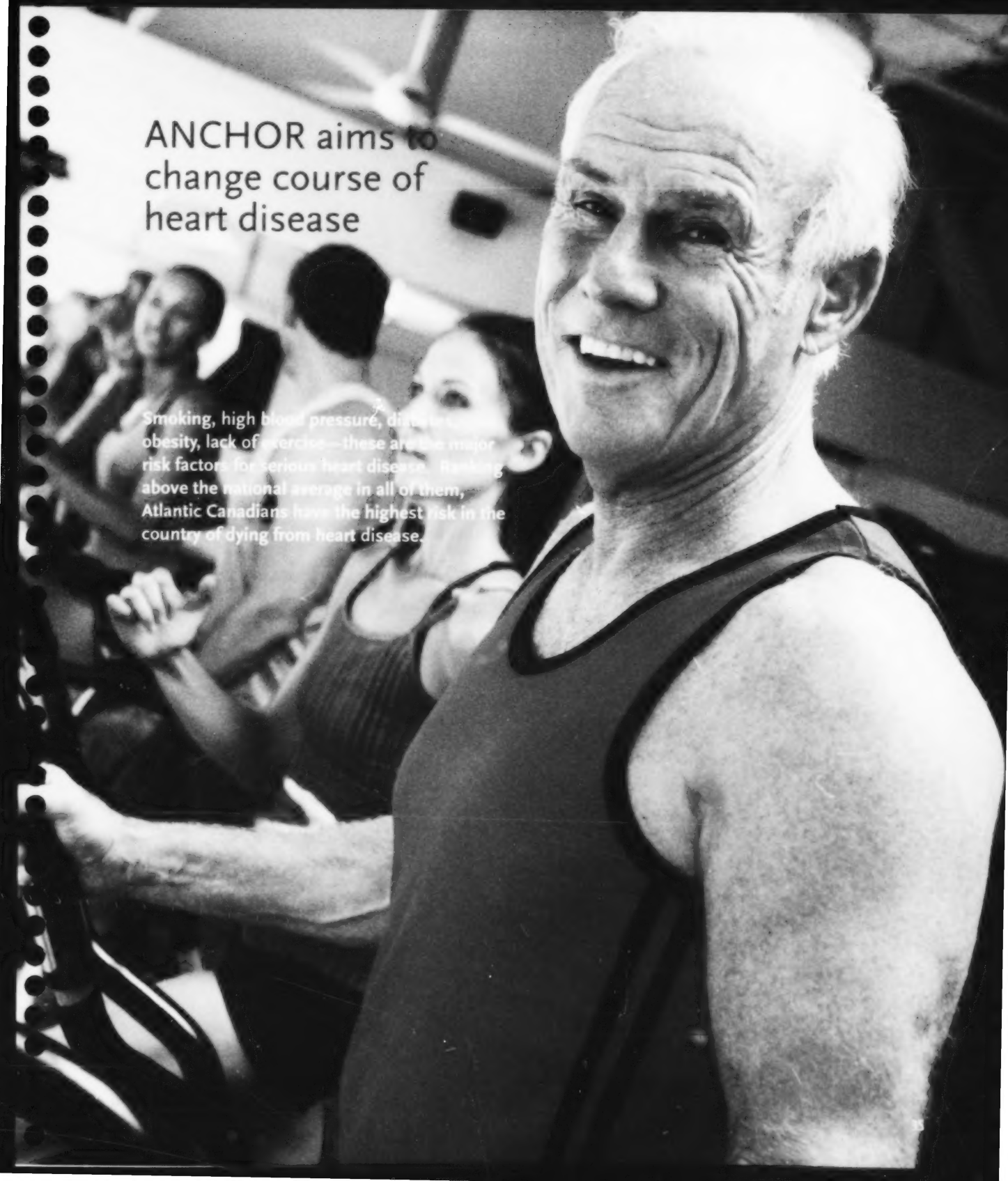
"Our goal was to encourage the strengths of community residents—to look at making lasting changes, not just surviving day to day," says Dawn-Marie Buck, director of community centres for the Saint John zone. "Hope, community pride, and community health are rising!"

To learn more about team-based primary health care in New Brunswick, see our online Backgrounder. www.healthcouncilcanada.ca

QUICK FACTS - NEW BRUNSWICK

- **Population: 750,000**
- **7 Community Health Centres**
- **7% of residents have access to teams in Community Health Centres**

ANCHOR aims to change course of heart disease



Smoking, high blood pressure, diabetes, obesity, lack of exercise – these are the major risk factors for serious heart disease. Ranking above the national average in all of them, Atlantic Canadians have the highest risk in the country of dying from heart disease.

In Nova Scotia, a project called ANCHOR began in 2006 to study ways to change that course and steer people at risk toward healthier behaviours. Like any good ship, ANCHOR runs on teamwork.

Adult patients at two primary care practices, one in Sydney and one in Halifax, are assessed for their risk of developing heart disease. At each site, a team consisting of family physicians, nurses, and dietitians works with each patient to set goals for making healthier choices, develop an individualized action plan, and measure their progress for one year.

ANCHOR stands for "A Novel Approach to Cardiovascular Health by Optimizing Risk Management" and is supported by a $2-million research grant from Pfizer Canada Inc. What's novel is the emphasis on motivating patients to take responsibility for their own health.

During the year, participants receive one-to-one counselling, telephone support, group education sessions, and referrals to extended team members—exercise specialists, physiotherapists, pharmacists—along with counselling and information about community resources to help patients stay focused on their goals.

> *Participants value the fact that it was self-directed. "There's nobody telling you, 'You have to do this,'" one person told the project's evaluation team. Instead, "it was 'Here's the information. Now what choices do you think you are ready to make?' and 'What do you think is going to stand in your way?'"*

The health data that emerge from the initial and follow-up risk assessment tests become a powerful tool for behaviour change. Each participant is given their personal numbers in a take-home binder that charts their progress through the categories of high, moderate, and low risk.

"All the scary numbers that say, 'You're in this category'—that ended up being my touchstone," a participant said. "When I was waffling and standing in the kitchen thinking, 'I'm going to get that bag of chips,' I'd open the binder. I found it very defining."

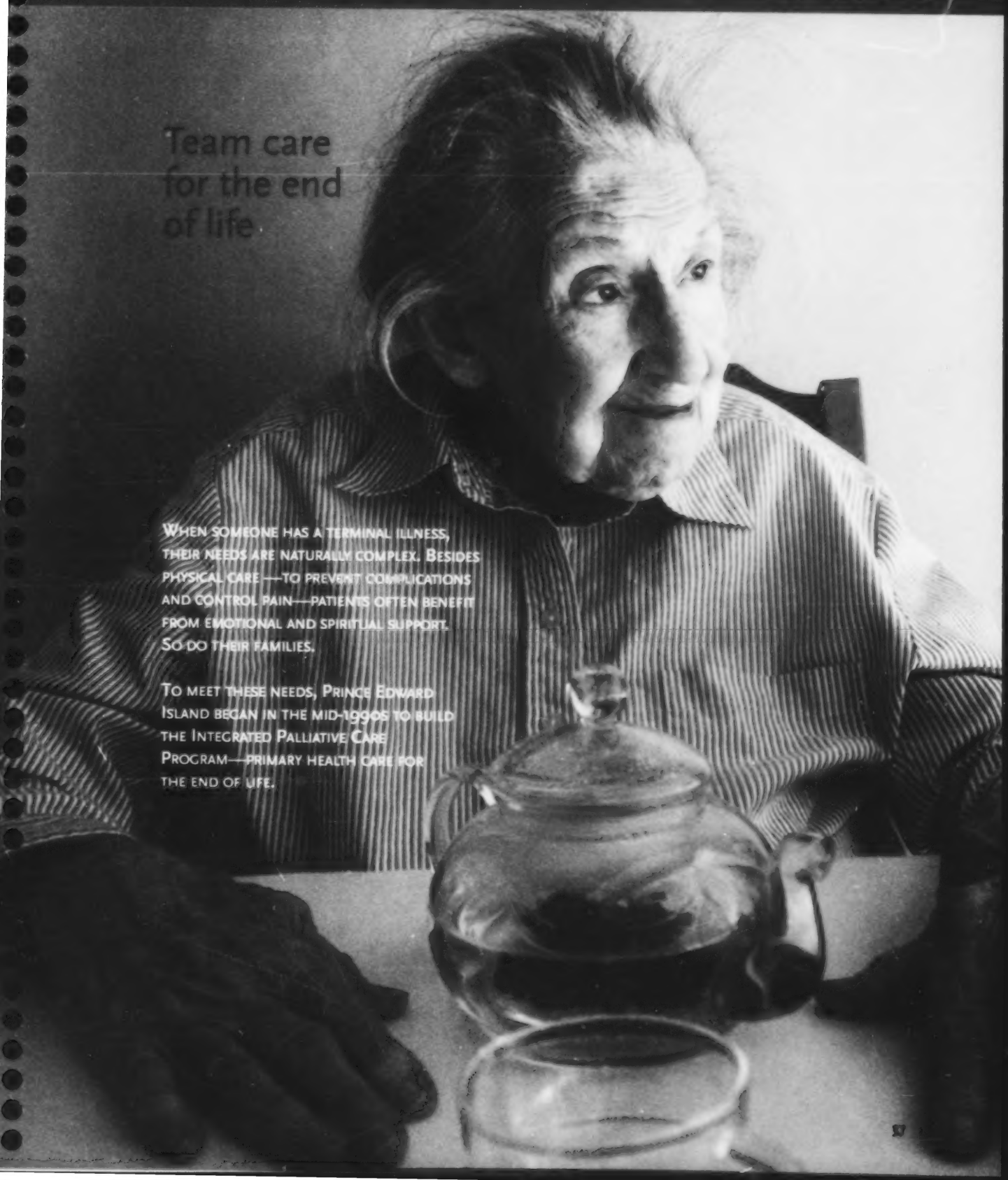
Preliminary results of the ANCHOR approach are very promising. A healthy percentage of participants have been able to reduce their risk of developing heart disease by making positive changes to their lifestyle and using medication appropriately. One driving force in the project's success has been the reduction in the number of participants with metabolic syndrome, a cluster of conditions (including high blood sugar, high blood pressure, and belly fat) that indicates a high risk of developing diabetes and heart disease.

For more information about ANCHOR, see www.anchorproject.ca, and to learn more about primary health care teams in Nova Scotia, see our online Backgrounder. www.healthcouncilcanada.ca

QUICK FACTS - NOVA SCOTIA

- **Population: 940,000**
- **73 primary health care teams**
- **10% of physicians work in interdisciplinary teams**

Teams in Action: Prince Edward Island



Team care for the end of life

When someone has a terminal illness, their needs are naturally complex. Besides physical care—to prevent complications and control pain—patients often benefit from emotional and spiritual support. So do their families.

To meet these needs, Prince Edward Island began in the mid-1990s to build the Integrated Palliative Care Program—primary health care for the end of life.

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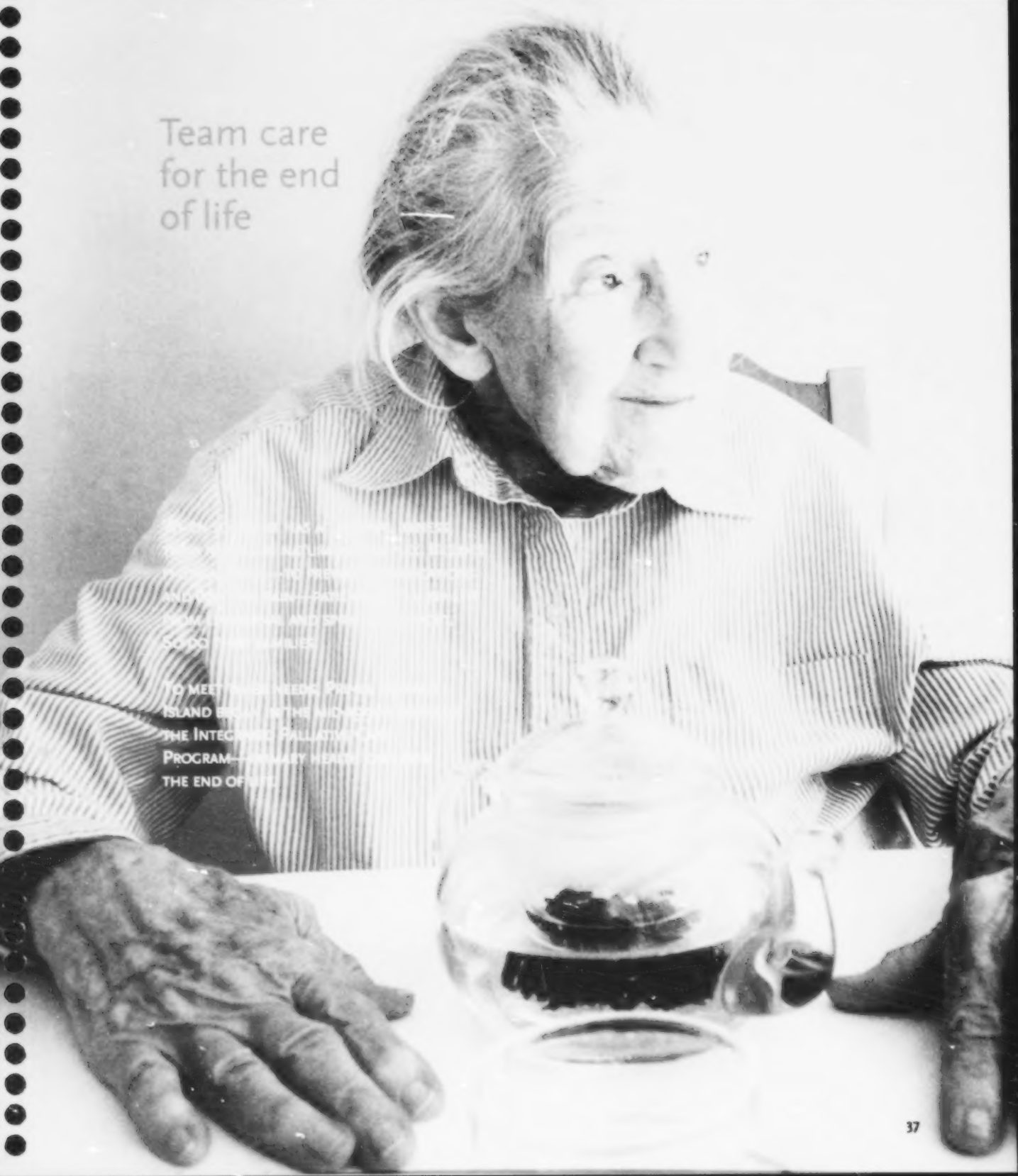

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Four palliative care teams cover the province, one in Charlottetown, one in Summerside, and two covering rural PEI. Each team includes family physicians and home care nurses with training in palliative care, and they are supported by other doctors and nurses (such as the provincial palliative care medical consultant and a provincial palliative resource nurse), a social worker, pharmacist, and a chaplain. All these professionals also have training in palliative care, in areas such as pain management, grief, spirituality, and helping patients and their families make decisions about end-of-life care.

The core members of the East Prince palliative care team trained together 10 years ago and have worked together since then. That consistency is an important factor in the team's ability to provide integrated care.

Teams work with patients at home, in hospital, and in long-term care, and the team members involved will differ depending on each patient's and family's needs. The palliative care teams work closely with PEI's home care teams, because many people prefer to die at home rather than in an institution. To reduce duplication for families as much as possible, the home care and palliative care teams coordinate the referral process and share common standards of care.

Palliative care teams also work with primary health care teams at the Island's Family Health Centres. These centres focus on team-based care, particularly for people with chronic diseases.

PEI has embarked on a major reform of its health care system, with an emphasis on integrating all aspects of care and expanding access to home care. Making palliative care more accessible to patients at home is one goal of these reforms.

QUICK FACTS - PRINCE EDWARD ISLAND

- **Population: 140,000**
- **33% of family doctors work in teams**
- **25% of Islanders will be served by Family Health Centres, when the number of centres grows from 5 to 7 (in the works)**
- **19 primary health care teams with 3 more planned**

"He wanted to be home. We wanted him to be home. But we weren't managing his pain very well," said a woman whose husband had terminal cancer and became a client of the East Prince palliative care team. "The whole team became the go-between for us and our family doctor. They could come in, and chat with us for an hour, and get the whole picture," she says, relief evident from her smile.

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The East Prince palliative care team is featured in a Health Council of Canada video, "Health Care Renewal in Canada: Integrated Palliative Care Program". Watch it on our Online Library. PEI has other kinds of primary health care teams, such as those that focus on public health or mental health and addictions. To learn more, see our online Backgrounder. www.healthcouncilcanada.ca

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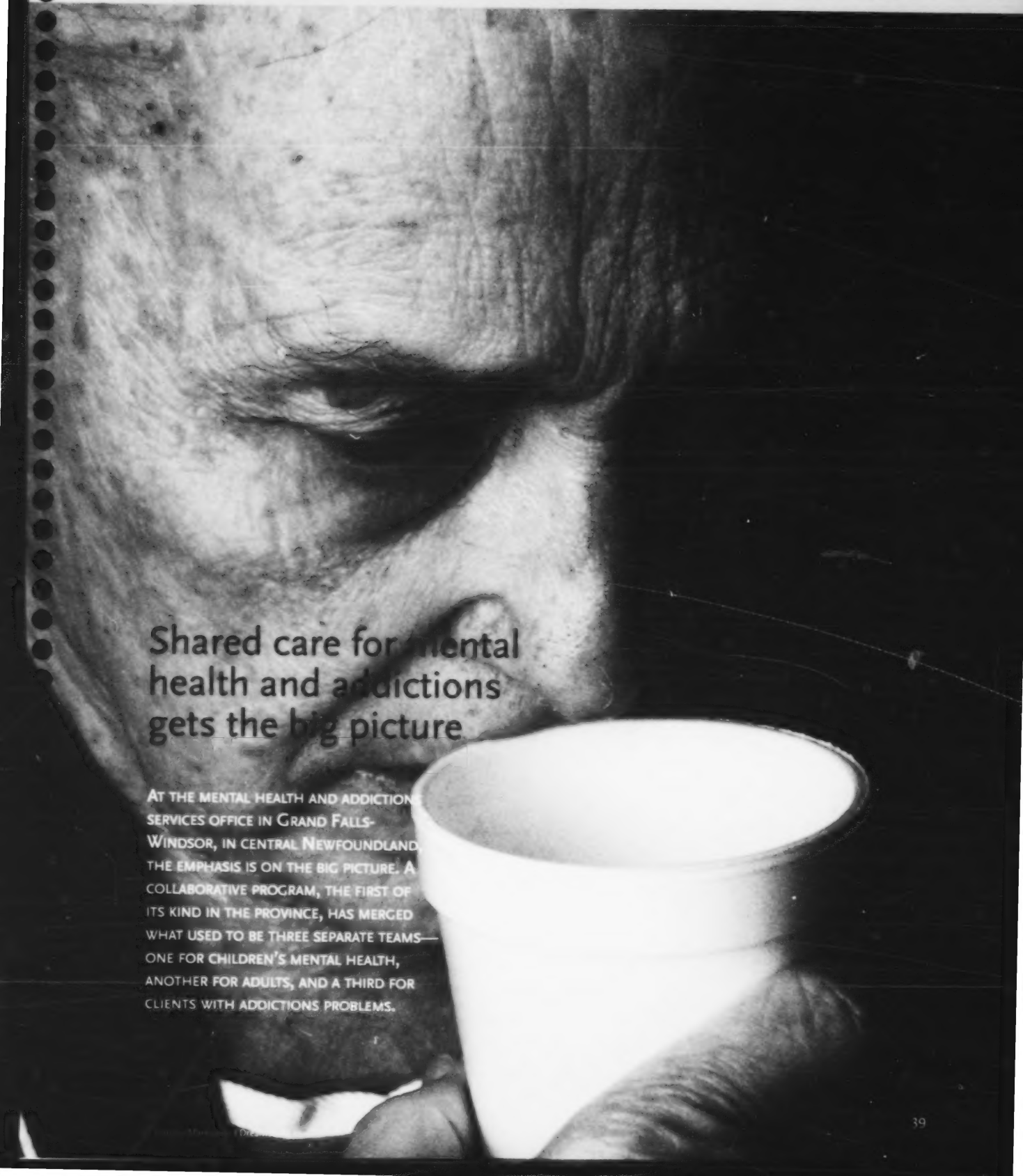
Teams in Action: Newfoundland and Labrador



Shared care for mental health and addictions gets the big picture

At the Mental Health and Addiction Services office in Grand Falls-Windsor, in central Newfoundland, the emphasis is on the big picture. A collaborative program, the first of its kind in the province, has merged what used to be three separate teams—one for children's mental health, another for adults, and a third for clients with addictions problems.

Four palliative care teams cover the province, one in Charlottetown, one in Summerside, and two covering rural PEI. Each team includes family physicians and home care nurses with training in palliative care, and they are supported by other doctors and nurses (such as the provincial palliative care medical consultant and a provincial palliative resource nurse), a social worker, pharmacist, and a chaplain. All these professionals also have training in palliative care, in areas such as pain management, grief, spirituality, and helping patients and their families make decisions about end-of-life care.

The core members of the East Prince palliative care team trained together 10 years ago and have worked together since then. That consistency is an important factor in the team's ability to provide integrated care.

Teams work with patients at home, in hospital, and in long-term care, and the team members involved will differ depending on each patient's and family's needs. The palliative care teams work closely with PEI's home care teams, because many people prefer to die at home rather than in an institution. To reduce duplication for families as much as possible, the home care and palliative care teams coordinate the referral process and share common standards of care.

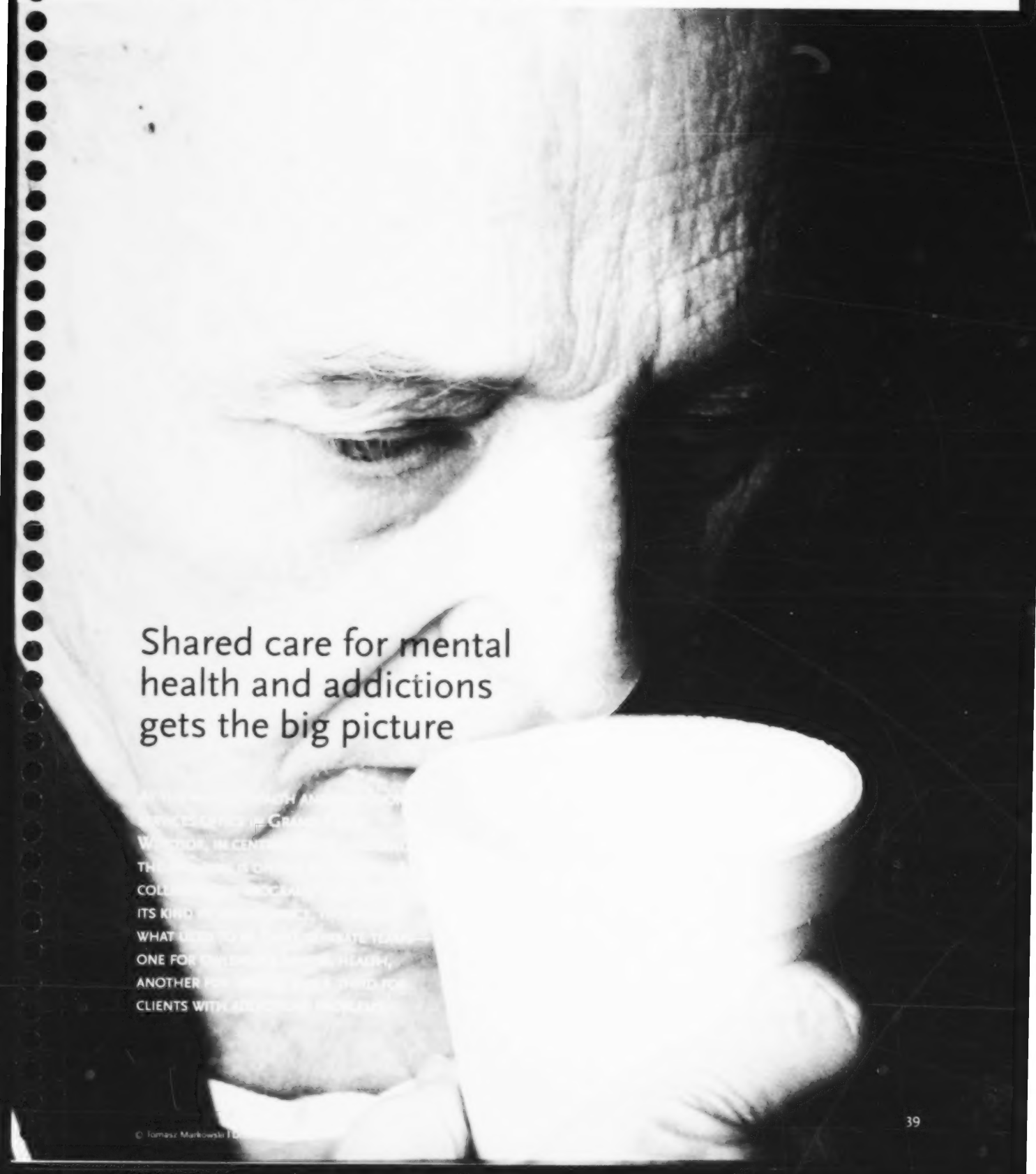
Palliative care teams also work with primary health care teams at the Island's Family Health Centres. These centres focus on team-based care, particularly for people with chronic diseases.

PEI has embarked on a major reform of its health care system, with an emphasis on integrating all aspects of care and expanding access to home care. Making palliative care more accessible to patients at home is one goal of these reforms.

QUICK FACTS - PRINCE EDWARD ISLAND

- **Population: 140,000**
- **33% of family doctors work in teams**
- **25% of Islanders will be served by Family Health Centres, when the number of centres grows from 5 to 7 (in the works)**
- **19 primary health care teams with 3 more planned**

Teams in Action: Newfoundland and Labrador



Shared care for mental health and addictions gets the big picture

"Patients told us, 'I want to tell my story once, not three times,'" says Charmaine Wight, a regional manager for mental health and addictions in the sprawling Central Health regional authority. Changes to better coordinate care began in 2001, when the province was shifting the focus of mental health care away from hospitals and into community services. A few years later, the amalgamation of smaller regional health authorities into eight larger ones opened another opportunity to break new ground, Wight explains.

The result is more comprehensive and more streamlined care for what are often complex and challenging issues. Social workers, nurses, and an occupational therapist—all with special training in mental health—work in the same office with psychologists and addictions counsellors. Each brings a unique professional perspective, and together they review new cases and collaboratively move their clients through a plan of care.

For example, if a child is referred to the program because of behaviour problems, the social worker focuses on family history while the nurse concentrates on the mental health of the child and adults. Because they share their expertise and the process of assessing new clients, the team quickly discovers that one of the parents has a substance abuse problem. Now the team looks at the family as a whole, offers the most appropriate services, and helps to create a better chance that the family will get the right help.

"It's not that clients are withholding information, but they may not make these connections for themselves between addictions and mental health," Wight says. The shared-care approach helps patients see how the pieces of their fractured lives fit together, so they can begin to regain mental health.

A strong working relationship with physicians adds to the program's ability to respond to patients' needs. "Psychiatrists, family doctors, pediatricians—we consider them part of our team, even though they are not in the same room," Wight says. "We have excellent reporting back to them if they have referred patients to us, and they do the same with us." Good communication emerged as a big concern when Central Health consulted with health care providers in the region about how best to redesign services.

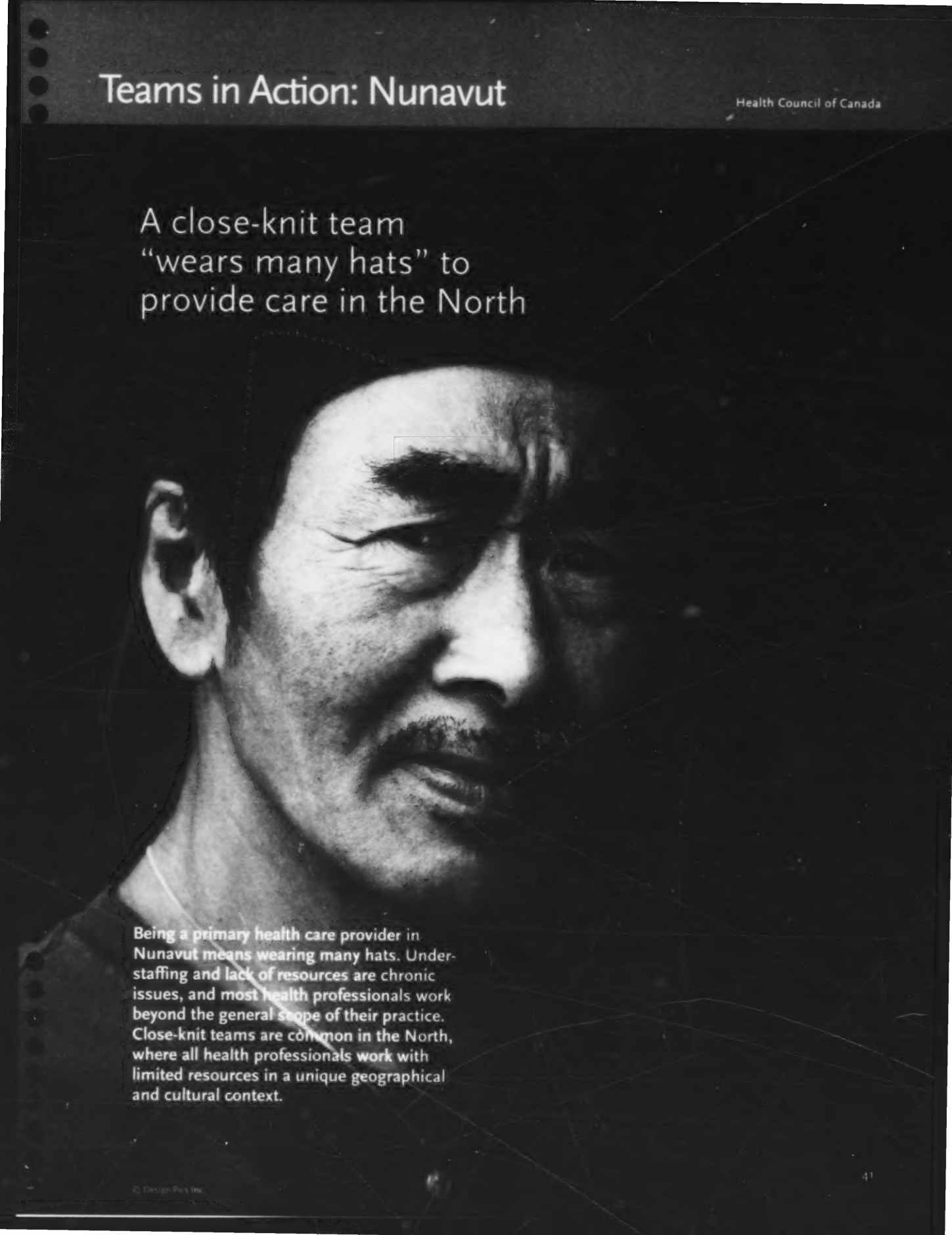
The program's biggest challenge now is wait times for its services. With more than 350 clients currently, the team is able to assess urgent referrals within five days, but clients referred on a non-urgent basis may wait up to a month for their first visit. To alleviate the pressure, some clients—such as people referred (non-urgently) for anxiety or depression—are offered group services, and patients have given these services good reviews, Wight says.

To learn more, see our online Backgrounder on primary health care teams in Newfoundland and Labrador. www.healthcouncilcanada.ca

QUICK FACTS - NEWFOUNDLAND AND LABRADOR

- Population: 508,000
- 11 primary health care team areas
- 27% of population served by teams

A close-knit team "wears many hats" to provide care in the North



Being a primary health care provider in Nunavut means wearing many hats. Understaffing and lack of resources are chronic issues, and most health professionals work beyond the general scope of their practice. Close-knit teams are common in the North, where all health professionals work with limited resources in a unique geographical and cultural context.

At the Kivalliq Health Centre in Rankin Inlet, a primary health care team works together to provide both primary health care, including a birthing centre, as well as acute care (secondary assessment and treatment, specialist services, ultrasound, and radiology). The team consists of nurses, midwives and midwifery workers, a physiotherapist, occupational therapist, speech pathologist, public health nurse, X-ray technicians, laboratory technicians, a medevac team and a general practitioner. In addition, physician specialists visit Rankin Inlet on a rotating schedule throughout the year to conduct assessments and plan patients' care.

The Kivalliq team tailors its care and healthy living advice to the health and social issues specific to the largely Inuit population. As one example, tuberculosis rates are 70 times the Canadian average. Regular screening and "thinking TB" are a part of the assessment in the Kivalliq. Cultural sensitivity is also part of the team's philosophy, respecting the traditions of the Inuit. The team includes three Inuit nurses, allowing residents the comfort of communicating in their first language and helping other staff understand their patients' cultural needs.

Another strength of the team is what's called a "shared care" approach, in which a nurse, physiotherapist, or birthing centre staff have the authority to refer a patient to a doctor. "Usually a doctor controls the gate," says Linda Sawyers, supervisor of the Community Health Program. "But doctors aren't always available, and there has to be a system where nurses and other providers can work in an expanded role."

Nurses serve as the primary providers; they are well trained in emergency services and can prescribe certain medications. The team approach helps overcome the limitations of lack of resources and staff, thanks to the ability to quickly refer patients or to call on other members of the team as required.

A recent story provides a vivid illustration of this teamwork. In 2008, during a five-day blizzard, a patient overdosed and suffered liver failure. The weather prevented the medevac team from landing to provide transport.

> *"The team rallied together with a 24-hour schedule to keep watch and monitor liver function, calling in lab, social services and mental health support," says Sawyers.*

Arrangements were made with a local airline to provide a pilot and prop plane. Two nurses and a physician were able to take off with the patient as soon as the weather began to clear and meet the medevac jet in Churchill.

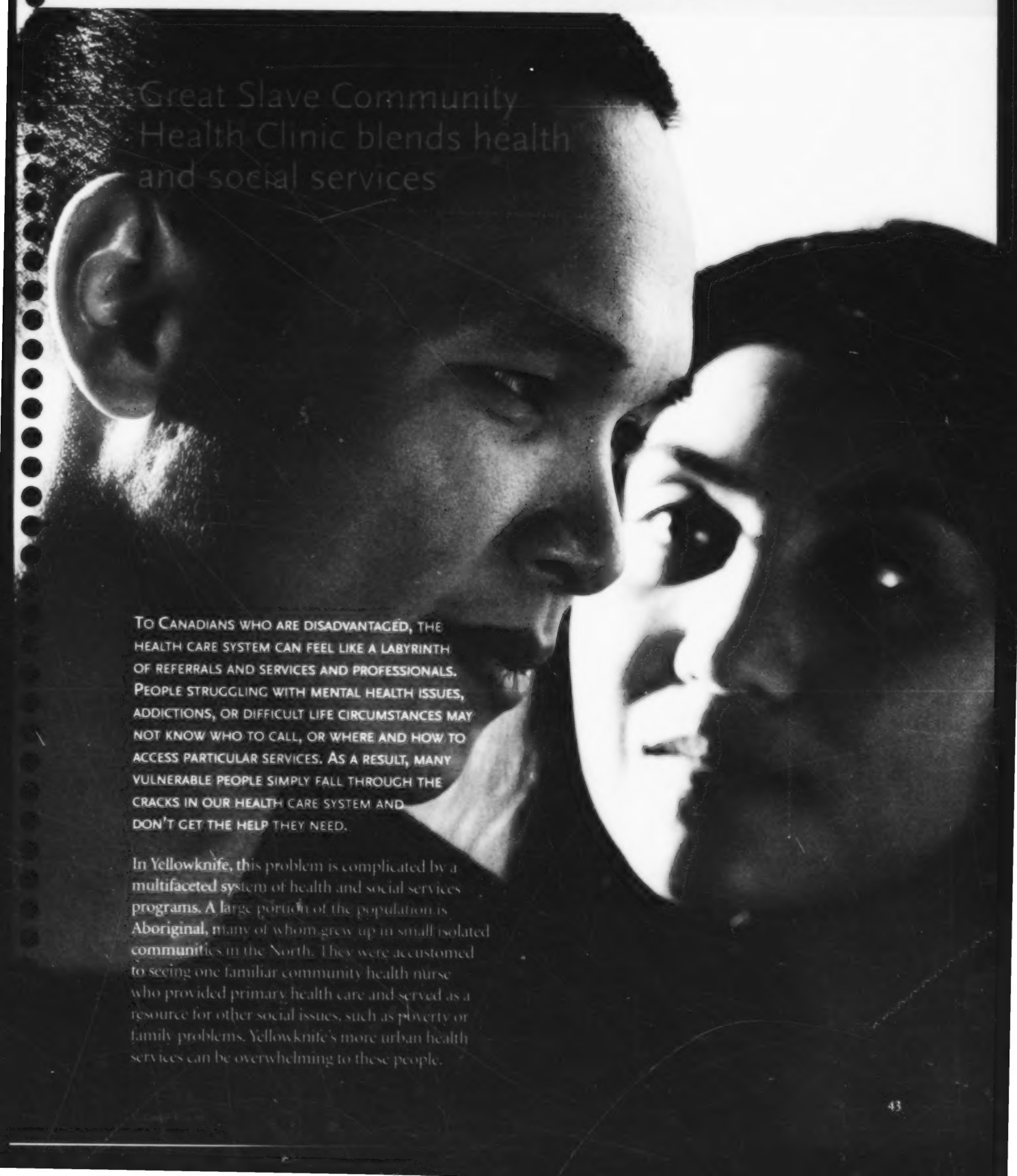
Although anecdotal evidence indicates that the team-based centre is making a difference to the community, it will be several years before centre staff have more concrete information. Last year, Rankin Inlet took part in the Inuit Health Survey, led by McGill University. This is a comprehensive look at Inuit health in the Kivalliq Region of Nunavut. Staff at the Kivalliq Health Centre received feedback from the survey, and when it is repeated in two or three years, they'll be able to see what changes have occurred.

To learn more about primary health care teams in Nunavut, see our online Backgrounder. www.healthcouncilcanada.ca

QUICK FACTS - NUNAVUT

- **Population: 31,000**
- **1.9 million square kilometres**

Teams in Action: Northwest Territories



Great Slave Community Health Clinic blends health and social services

TO CANADIANS WHO ARE DISADVANTAGED, THE HEALTH CARE SYSTEM CAN FEEL LIKE A LABYRINTH OF REFERRALS AND SERVICES AND PROFESSIONALS. PEOPLE STRUGGLING WITH MENTAL HEALTH ISSUES, ADDICTIONS, OR DIFFICULT LIFE CIRCUMSTANCES MAY NOT KNOW WHO TO CALL, OR WHERE AND HOW TO ACCESS PARTICULAR SERVICES. AS A RESULT, MANY VULNERABLE PEOPLE SIMPLY FALL THROUGH THE CRACKS IN OUR HEALTH CARE SYSTEM AND DON'T GET THE HELP THEY NEED.

In Yellowknife, this problem is complicated by a multifaceted system of health and social services programs. A large portion of the population is Aboriginal, many of whom grew up in small isolated communities in the North. They were accustomed to seeing one familiar community health nurse who provided primary health care and served as a resource for other social issues, such as poverty or family problems. Yellowknife's more urban health services can be overwhelming to these people.

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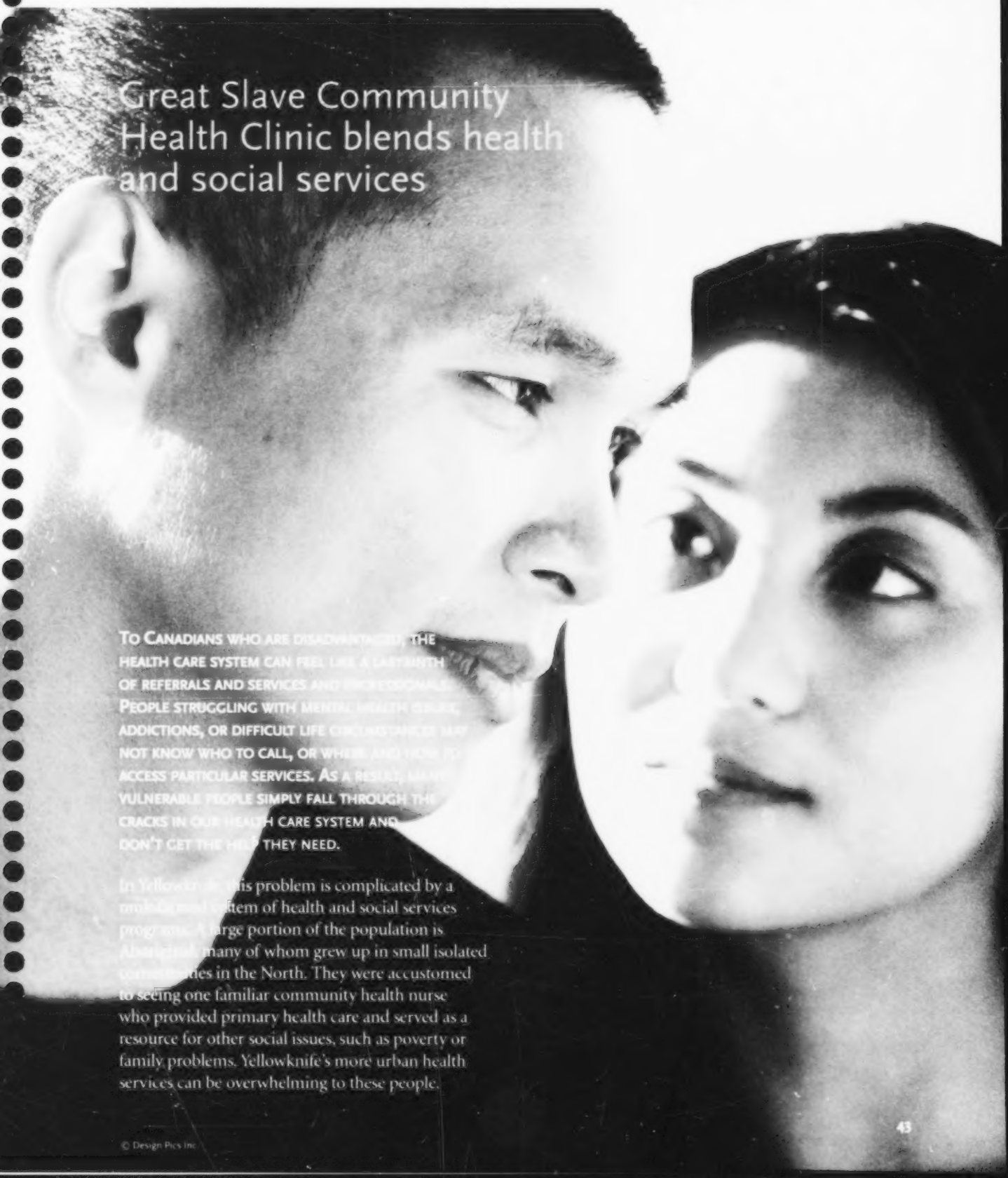


To Canadians who are disadvantaged, the health care system can feel like a labyrinth of referrals and services and professionals. People struggling with mental health issues, addictions, or difficult life circumstances may not know who to call, or where and how to access particular services. As a result, many vulnerable people simply fall through the cracks in our health care system and don't get the help they need.

In Yellowknife, this problem is complicated by a multicultural system of health and social services programs. A large portion of the population is Aboriginal, many of whom grew up in small isolated communities in the North. They were accustomed to seeing one familiar community health nurse who provided primary health care and served as a resource for other social issues, such as poverty or family problems. Yellowknife's more urban health services can be overwhelming to these people.

> *"When we try to force these clients to seek out many services at different sites, it is too much. We lose them," says Jill Christensen, manager of Integrated Services for the Yellowknife Health and Social Services Authority. The Great Slave Community Health Clinic—a one-stop-shopping site for primary health care—is Yellowknife's answer to reaching these vulnerable populations.*

The clinic was established in 2005 to target populations that are at high risk for health problems, including Aboriginal and immigrant families, youth, people with mental health challenges, the homeless, and the working poor. To help determine what their future patients needed most, the clinic's planners went directly to the people they were trying to reach through a series of group and one-to-one consultations.

What they learned: People needed help in learning how to prevent and treat sexually transmitted diseases (the North has the highest rates of these conditions in Canada). They needed help with their addictions. And they needed help with social issues such as poverty and finding adequate housing.

The resulting clinic is a creative blend of health care and social services. Without any new funding for staff, the clinic planners pulled professionals from other programs elsewhere in the city to work together in one building. In addition to doctors, nurses, and nurse practitioners, the clinic houses a public health nurse who specializes in sexually transmitted diseases, a mental health worker who provides short-term counselling, and a community outreach worker who help patients through the steps and forms required to obtain housing and social assistance and who networks with other community agencies to hunt down clothing, furniture, food, and other needs. The community outreach worker is staffed through a non-profit organization, part of the clinic's intent to offer both government and non-government services under one roof. Addictions counselling is provided a block away through a collaborative arrangement with a sister community organization that already had an established program.

With this model, patients get to know familiar faces and develop levels of trust. This allows staff to learn about their lives and to provide more help. The Great Slave Community Health Clinic also provides outreach services, operating a one-day-a-week physician and nurse practitioner clinic at the Centre for Northern Families. In addition, the team's public health nurse offers a one-day-a-week sexual health and well-being clinic at the same location. Offering services on-site creates an opportunity to collaborate with staff of the centre and improve services for patients.

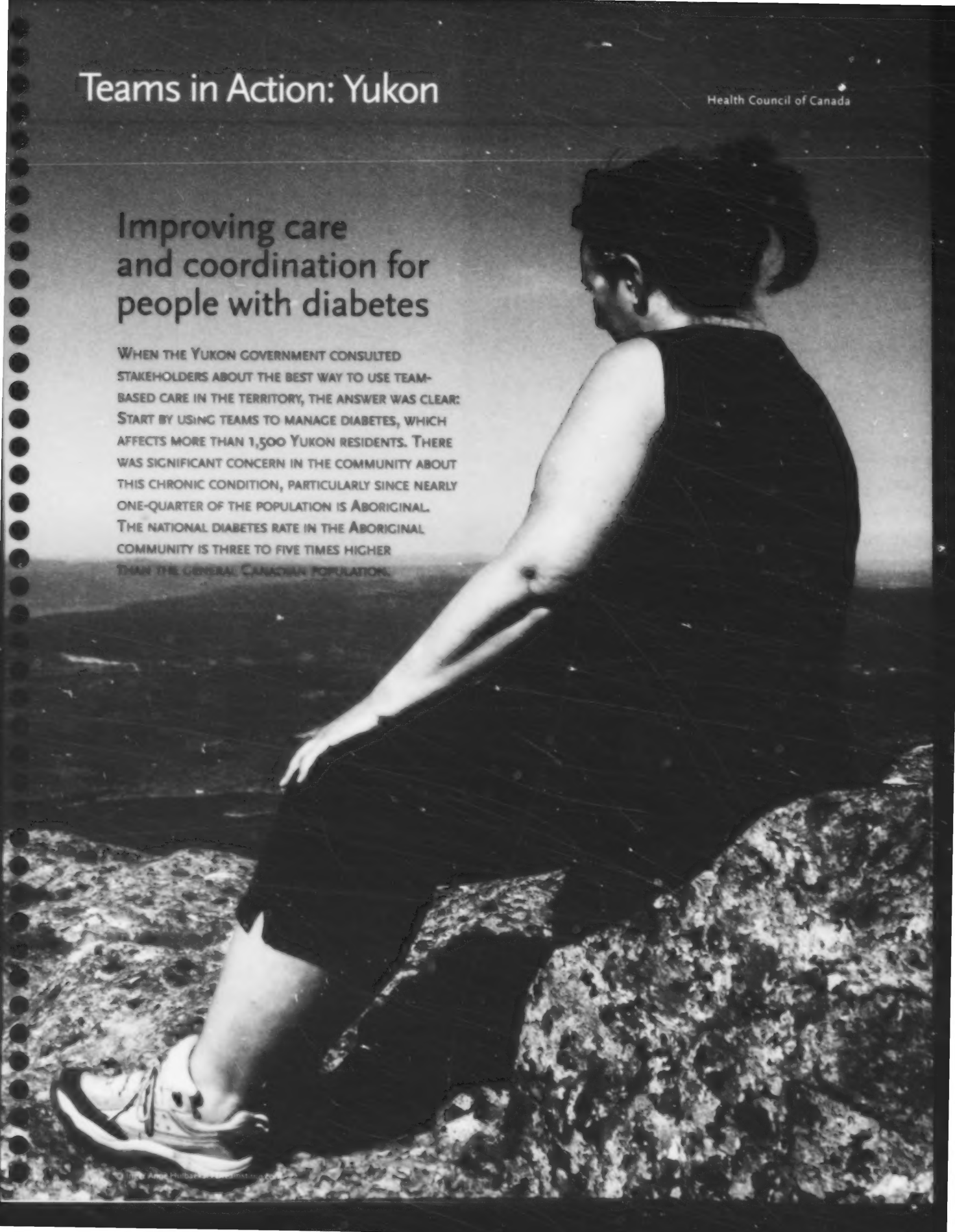
"If they aren't able to come to us, then we'll go to them," says Christensen.

QUICK FACTS - NORTHWEST TERRITORIES

- **Population: 43,000**
- **1.1 million square kilometres**
- **More than 50% of population is of Aboriginal descent**
- **Official languages: English, French, and 9 Aboriginal languages**

Improving care and coordination for people with diabetes

When the Yukon government consulted stakeholders about the best way to use team-based care in the territory, the answer was clear: Start by using teams to manage diabetes, which affects more than 1,500 Yukon residents. There was significant concern in the community about this chronic condition, particularly since nearly one-quarter of the population is Aboriginal. The national diabetes rate in the Aboriginal community is three to five times higher than the general Canadian population.



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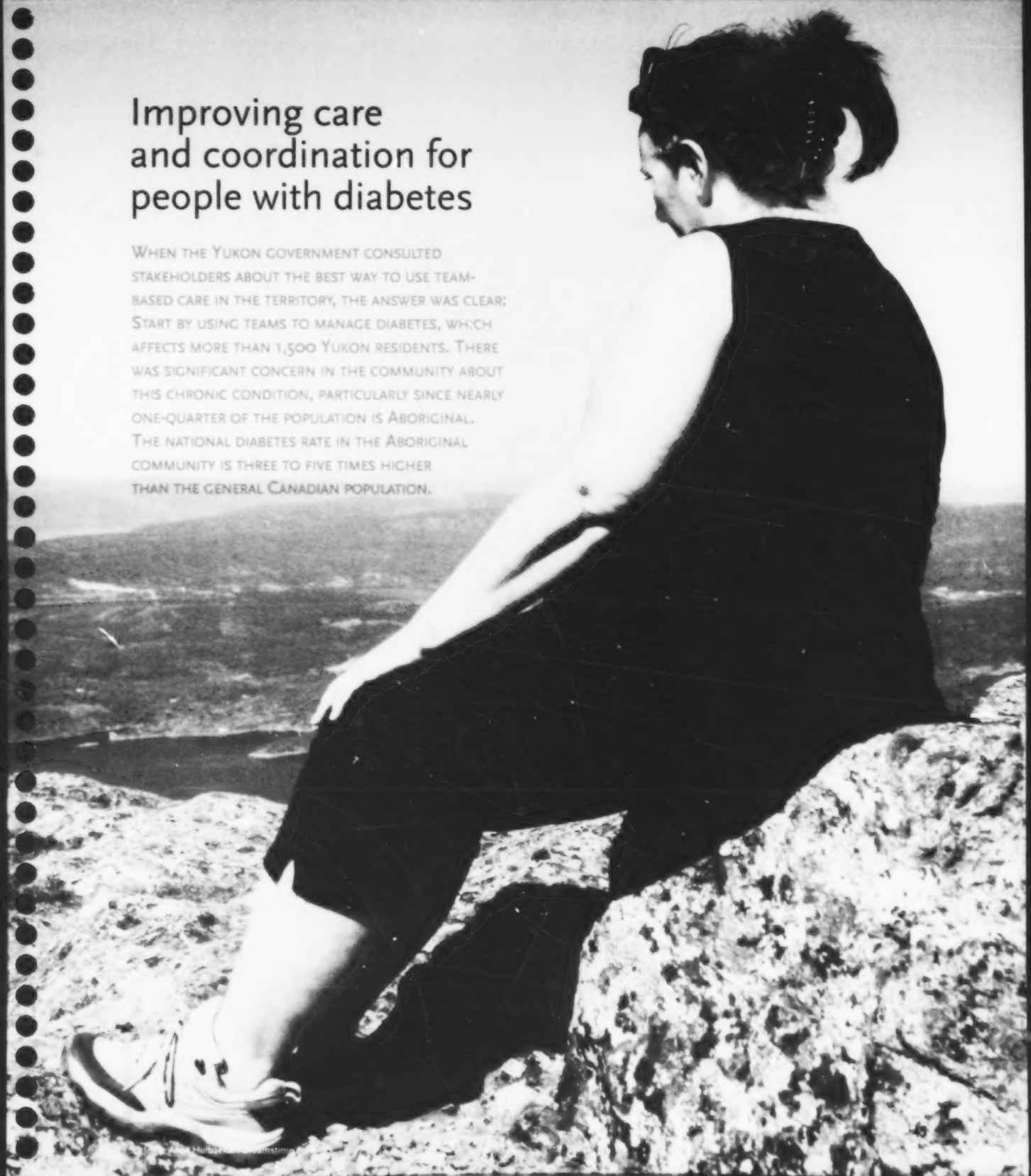


The resulting team, called the Diabetes Collaborative, is based in Whitehorse but also works with health care providers in rural Yukon communities. The collaborative is based on a successful chronic care program in BC, which focuses on both health promotion and helping patients manage their chronic conditions more effectively.

Serious and long-term complications from diabetes—such as heart attack, kidney failure, and amputations—affect an estimated 40% of people with diabetes, despite the fact that these poor outcomes can often be delayed or prevented. The best defence against complications from diabetes is careful management of blood sugar, fats in the blood (such as cholesterol), blood pressure, and weight. The Canadian Diabetes Association sets national clinical guidelines for a regular schedule of diabetes tests, but a substantial number of people in Canada don't receive this "gold standard" of care.

Since the Diabetes Collaborative began in 2005, more people in the Yukon are now receiving the care that experts recommend. The majority of people with diabetes in Whitehorse have been enrolled in a computerized patient registry through their family physician or primary health care nurse. An online chronic disease management toolkit allows health care providers to create a patient registry that includes a flow sheet for each patient, used to enter and review information such as test results. Among other features, the toolkit has built-in reminders to ensure that patients are called in at recommended intervals for tests—an invaluable feature for busy health professionals. To help ensure that the toolkit is used effectively, staff of the Diabetes Collaborative visit physicians' offices and health centres to enter the baseline data about patients and get the online toolkit started.

On an ongoing basis, nurses and a physiotherapist in the collaborative work alongside doctors in their offices, where they provide advice to patients on healthy living and managing diabetes more effectively. They also monitor patients' tests and results through the database and follow up as needed. Working on-site in the doctors' offices allows the doctors, nurses, and physiotherapist to work as a collaborative team, and patients' care is more streamlined. Other health professionals in the collaborative—such as dietitians and pharmacists—are involved as needed.

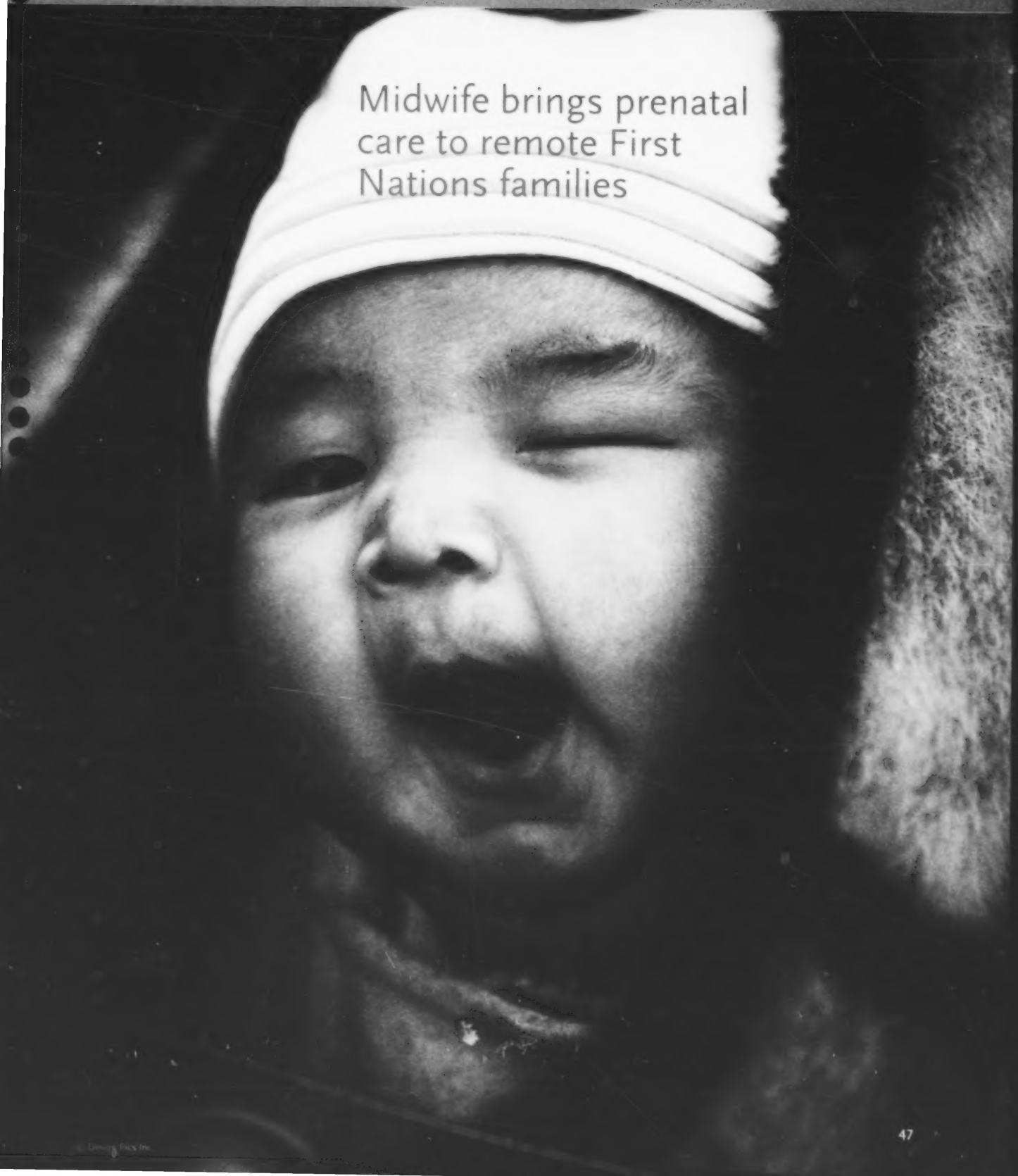
The results? The Diabetes Collaborative has been described as a Yukon health care success story, showing significant improvements for patients. As one example, over a 16-month period, the number of patients receiving recommended tests for their blood sugar levels increased from 56% to 70%, and LDL cholesterol testing increased from 67% to 87%. Health providers appreciate the way the collaborative has allowed them to work better together to improve their patients' health.

With the success of the Diabetes Collaborative, the Yukon government now intends to expand this model of team-based care to other communities and chronic conditions.

To learn more about primary health care teams in Yukon, see our online Backgrounder, www.healthcouncilcanada.ca

QUICK FACTS - YUKON

- Population: 33,000
- 2/3 of population live in Whitehorse
- 64 family physicians



Midwife brings prenatal care to remote First Nations families

THE O'CHIESE AND SUNCHILD FIRST NATIONS ARE AN HOUR'S DRIVE OVER GRAVEL ROADS FROM THE NEAREST DOCTORS IN THE SMALL TOWN OF ROCKY MOUNTAIN HOUSE IN WEST-CENTRAL ALBERTA. ABOUT 1,000 PEOPLE LIVE IN EACH COMMUNITY, AND PRENATAL CARE IS PARTICULARLY IMPORTANT FOR THE HEALTH OF THESE YOUNG POPULATIONS. ABOUT ONE-THIRD OF RESIDENTS ARE UNDER 16 YEARS OLD, AND BIRTH RATES ARE HIGH. BUT GETTING INTO TOWN FOR PRENATAL CARE IS NOT EASY.

Winter weather compounds the challenge. Add the need to arrange care for other babies and children, and it's no wonder that most pregnant women from the two small communities were arriving to give birth at the Rocky Mountain House hospital without having received the recommended routine of prenatal care.

Regular prenatal care vastly improves a woman's chances of having an uncomplicated delivery and a healthy baby. At the small hospital in Rocky Mountain House, women who arrive without adequate prenatal care are considered to be at risk of complications and have to be transferred to Red Deer, 80 km away, or sometimes to Edmonton, more than 150 kilometres further. In 2006, one-third to half of all births among mothers from O'Chiese and Sunchild took place in Red Deer or Edmonton. In 2007, 78% of pregnant women from the First Nations had fewer than six prenatal visits when their babies were born (compared to 13% of mothers from town), and many of them had never had a blood test or ultrasound to check their own or their baby's health.

The solution? Hire a registered midwife to visit the First Nations four days each month and be part of the area's Primary Care Network. The midwife, who started in early 2008, provides the full range of prenatal care that a family doctor would normally. She also works closely with the on-reserve community health nurses (who provide education for healthy pregnancy, birth, and infant care) and with the family doctors and obstetricians at the Rocky Mountain House hospital.

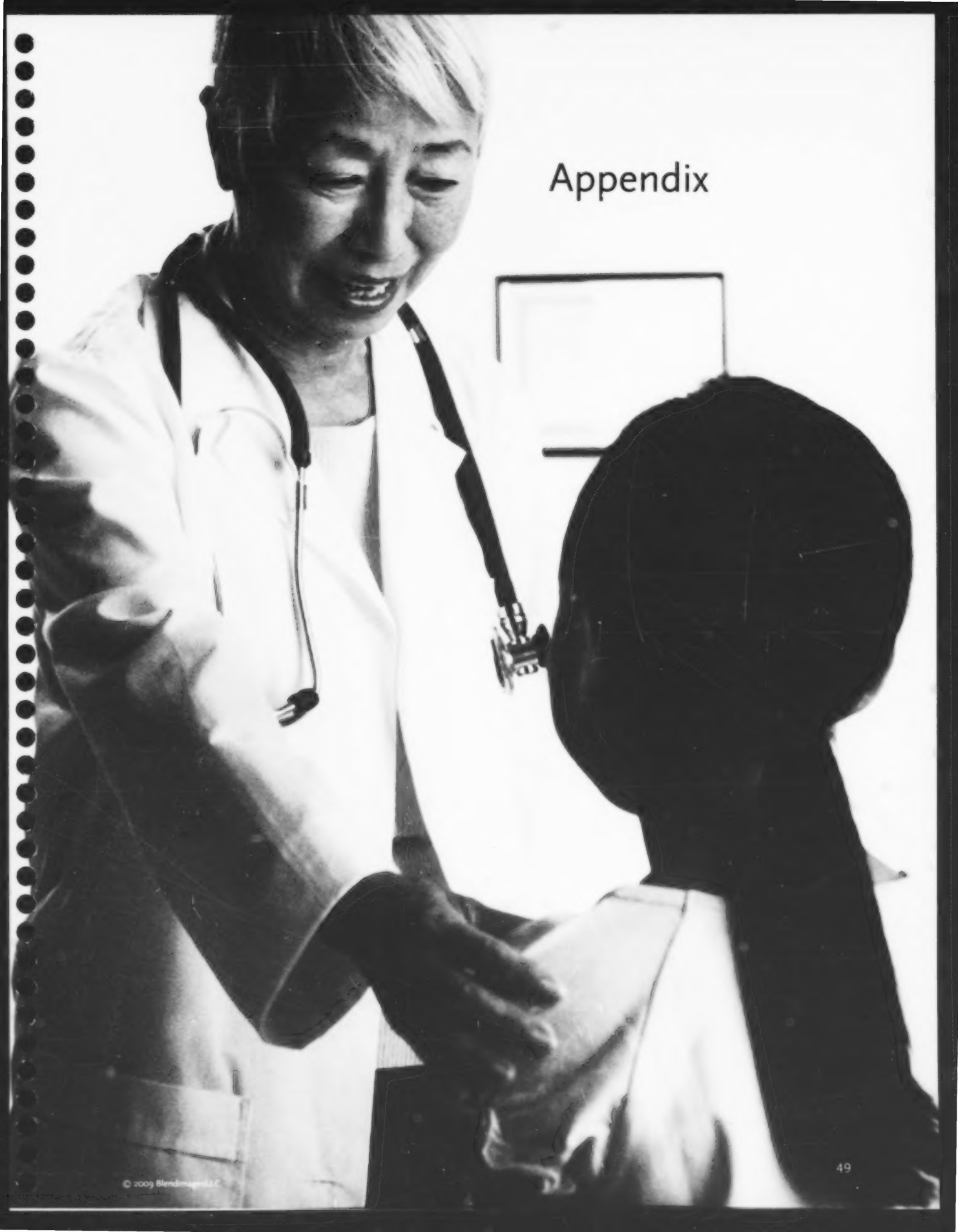
The Collaborative Shared Care Maternity Services is a five-year project that is being formally evaluated. The hard data to measure its success will come later, but in just the first six months, the team members were already seeing a big difference. More pregnant women were getting regular prenatal care, more were going to prenatal classes, and more were interested in breastfeeding their babies.

> *"It used to be a lot of work just getting them to the health centre. Now they feel that they are getting something important that is convenient and fun, and in their own community," one team member reported. "They are asking more questions. They are bringing their babies in for immunization. They feel we are helping them," said another.*

The shared-care program has other benefits as well. The midwife delivers about one-third of the babies at the hospital, taking the pressure off the eight family doctors who serve the whole Rocky Mountain House area. And news of the program's success is spreading. Women in another nearby First Nation and from outside the Rocky Mountain House service area have expressed interest in participating.

The Collaborative Shared Care Maternity Services project is a unique partnership among the Alberta Association of Midwives, Health Canada, First Nations and Inuit Health, Alberta Region, Rocky Mountain House Primary Care Initiative, O'Chiese First Nation, Sunchild First Nation, and David Thompson Health Region. To learn more about primary health care teams in First Nations and Inuit communities, as well as initiatives for members and veterans of the Canadian Forces, see our online Backgrounder, www.healthcouncilcanada.ca.

Appendix



WHAT GOVERNMENTS PROMISED

In the 2003 *First Ministers' Accord on Health Care Renewal*, governments agreed to the goal of ensuring that at least 50% of their residents have access to an appropriate health care provider, 24 hours a day, 7 days a week.

In the 2004 *10-Year Plan to Strengthen Health Care*, governments agreed to 50% of Canadians having 24/7 access to multidisciplinary teams by 2011.

The purpose of the 24/7 language in both the 2003 and 2004 goals was to ensure that more Canadians receive the primary health care they need after-hours, rather than going without or making unnecessary visits to hospital emergency departments.

In our 2008 report, *Fixing the Foundation: An Update on Primary Health Care and Home Care Renewal in Canada*, we reported that most jurisdictions use 24/7 telephone lines staffed by registered nurses to provide timely access to health information and advice. Some jurisdictions use strategies such as offering incentives to physicians who provide after-hours care or more flexible same-day scheduling. We encouraged jurisdictions to increase 24/7 access through after-hours clinics, shifts in physicians' work hours, scheduling efficiencies, and other strategies beyond telephone health lines, which are valuable but have limitations.[34]

In this report we comment on the 50% global target for team-based primary health care, but not on the issue of 24/7 access.

A HISTORY OF TEAMS IN CANADA

In order to strengthen health care in Canada, the prime minister and premiers (First Ministers) made significant investments over the past decade to improve access to and quality of primary health care, and committed to increase the proportion of Canadians who have access to teams.

- Between 1997 and 2001, the Health Transition Fund was established to support investments in demonstration projects that were designed to test new models of delivering care in the community. At that time, only four provinces required family physicians to work in groups and interdisciplinary teams as a precondition for funding.[35]

- In 2000, the First Ministers agreed on a vision for renewal—Action Plan for Health System Renewal—that included, among other things, additional investments in primary health care so that "Canadians receive the most appropriate care, by the most appropriate providers, in the most appropriate settings."

  First Ministers agreed "to promote the establishment of interdisciplinary primary health care teams that provide Canadians first contact with the health care system. Such teams would also focus on health promotion, the prevention of illness and injury, and improved management of chronic disease."

  They agreed to "accelerate primary health care renewal" and "work towards ensuring timely access to services outside of expensive emergency departments."[36]

- In 2000, the Government of Canada responded by announcing the Primary Health Care Transition Fund (PHCTF), which established a policy framework to guide the investment of $800 million over a six-year period, in support of implementing large-scale, primary health care renewal initiatives.

  Among the objectives of the PHCTF were "to establish multi-disciplinary teams, so that the most appropriate care is provided by the most appropriate provider," "to increase the emphasis on health promotion, disease and injury prevention, and chronic disease management," "to expand 24/7 access to essential services," and "to facilitate coordination with other health services (such as specialists and hospitals)."[20, 37]

- In 2003, the *First Ministers' Accord on Health Care Renewal* reaffirmed a national vision for primary health care renewal and established goals, objectives, and requirements for federal transfer payments for a newly established, five-year reform fund. In the accord, the First Ministers declared, "The core building blocks of an effective primary health care system are improved continuity and coordination of care, early detection and action, better information on needs and outcomes, and new and stronger incentives to ensure that new approaches to care are swiftly adopted and here to stay." They agreed to the goal that, by 2011, "at least 50% of their residents have access to an appropriate health care provider, 24 hours a day, 7 days a week."[38]

- In 2004, the First Ministers' *10-Year Plan to Strengthen Health Care* referred to an "objective of 50% of Canadians having 24/7 access to multidisciplinary teams by 2011."[21]

THE 2008 CANADIAN SURVEY OF EXPERIENCES WITH PRIMARY HEALTH CARE

The first survey of Canadian experiences in primary health care, funded by the Health Council of Canada, was conducted by Statistics Canada in 2007, with approximately 2,200 respondents. Statistics Canada has produced a paper summarizing the 2007 survey findings with regard to the effects of team care.[39]

In 2008, the Health Council of Canada and the Canadian Institute for Health Information co-funded the 2008 Canadian Survey of Experiences with Primary Health Care to provide new information about access, use, experiences, and outcomes among the general population, as well as adults who have chronic health conditions. These survey data offer pan-Canadian population-based estimates.

This cross-sectional telephone survey was conducted by Statistics Canada from April to June 2008 and administered in either French or English (depending on the preference of the survey participant). A total of 11,582 adults completed the survey. (These respondents came from a sample of 16,482 adults in the Canadian Community Health Survey, Cycle 4.1, who were approached to participate in the 2008 Canadian Survey of Experiences with Primary Health Care.)

LEARN MORE

About chronic conditions

Why Health Care Renewal Matters: Learning from Canadians with Chronic Health Conditions

Why Health Care Renewal Matters: Lessons from Diabetes

In 2007, the Health Council of Canada produced two comprehensive reports on the growing epidemic of chronic disease in Canada, and what can be done about it.

About teams

Getting It Right: Case Studies of Effective Management of Chronic Disease Using Primary Health Care Teams

In 2009, the Health Council of Canada commissioned a research team, led by Dr. Thomas Rathwell of Dalhousie University, to examine four Canadian and one international chronic illness care programs that use collaborative teams to deliver primary health care. This report serves as an experience-oriented tool for primary health care providers, planners, and decision-makers who wish to improve an existing program or implement a team-based approach for chronic disease management.

Canadian Health Services Research Foundation: Interprofessional Collaboration and Quality Primary Healthcare

In 2007, the Canadian Health Services Research Foundation and the Health Council of Canada commissioned a research team, led by Juanita Barrett, to gain a better understanding of the evidence regarding team-based care. The resulting research synthesis looked at both international and Canadian evidence on teams.

All of these reports are available at www.healthcouncilcanada.ca, as well as several videos about team-based care.

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Canada's First Ministers established the Health Council of Canada in the 2003 Accord on Health Care Renewal and enhanced our role in the 2004 10-Year Plan to Strengthen Health Care. We report on the progress of health care renewal, on the health status of Canadians, and on the health outcomes of our system. Our goal is to provide a system-wide perspective on health care reform for the Canadian public, with particular attention to accountability and transparency.

The participating jurisdictions have named Councillors representing each of their governments and also Councillors withexpertise and broad experience in areas such as community care, Aboriginal health, nursing, health education and administration, finance, medicine and pharmacy. Participating jurisdictions include British Columbia, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Nova Scotia, New Brunswick, Newfoundland and Labrador, Yukon, the Northwest Territories, Nunavut and the federal government. Funded by Health Canada, the Health Council operates as an independent non-profit agency, with members of the corporation being the ministers of health of the participating jurisdictions.

The Council's vision
An informed and healthy Canadian public, confident in the effectiveness, sustainability and capacity of the Canadian health care system to promote their health and meet their health care needs.

The Council's mission
The Health Council of Canada fosters accountability and transparency by assessing progress in improving the quality, effectiveness and sustainability of the health care system. Through insightful monitoring, public reporting and facilitating informed discussion, the Council shines a light on what helps or hinders health care renewal and the well-being of Canadians.

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